

Please call **901-322-4080** to schedule an appointment for an interview and functional assessment **AFTER** the completion of your application. Please **do not drop-off applications without an appointment.**

## ADA Paratransit Eligibility Application

**MATApplus Eligibility Center - 3033 Airways Blvd. - Memphis, TN 38131**

**NOTE:** Completion of the application is mandatory for approval.

**MATA will not process incomplete applications.**

**Faxed, emailed, or mailed applications are no longer accepted.**

The Memphis Area Transit Authority (MATA) will use this application as **1 of 4 steps** to determine eligibility for MATApplus (paratransit services). MATApplus is a curb-to-curb transportation service for individuals with disabilities who cannot use fixed-route buses. MATA's fixed-route services include bus and trolley transit. MATA bus/trolley services are fully accessible to individuals with disabilities. Individuals that cannot use fixed-route buses or the trolley can apply for MATApplus. **The applicant will need to complete this application and the medical verification form before the in-person interview and functional assessment to be certified. The applicant must complete the entire certification process for approval for MATApplus eligibility.** The steps to **eligibility** certification are as follows:

### STEP 1:

- Complete pages 2-3 (your demographic information and information about your disability)
- Have your Physician/Healthcare Services Provider complete and return **TO YOU** pages 4-6. **The Medical Verification of Disability Form.**

### STEP 2:

- Once you have a completed application, including the **Medical Verification of Disability Form.** call the Eligibility Center to schedule your interview and functional assessment. **(901) 322-4080.**
- Bring your completed MATApplus application to your scheduled interview and assessment

### STEP 3:

- Participate in a face-to-face interview with the MATApplus Compliance Specialist.
- All photos will be taken on the same day and location of the interview and assessment.
- If necessary, undergo a functional assessment (same-day and location).

### STEP 4:

- Participate in a functional assessment with the Functional Assessment Specialist.
- Depending on the outcome of all four steps – you may be granted certification within twenty-one (21) business days following the interview and assessment. All information will be mailed to the applicant.

**PLEASE COMPLETE THE ENTIRE APPLICATION**

**PART I – General Information to be completed by you, the applicant, or your representative (Please legibly print or type in blue or black ink)**

**Application Type (please check one)**

**Original Certification**

**Recertification**

**First Name:** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_

**How do you identify**

**Male**  **Female**  **Other**  **Date of Birth**

<i>MM</i>	<i>DD</i>	<i>YYYY</i>
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\_\_\_\_\_  
**Street Address** **City/State/Zip Code** **Apartment #**

\_\_\_\_\_  
**Alternate Street Address** **City/State/Zip Code** **Phone #**

\_\_\_\_\_  
**Alternate Phone Number** **Email address** **Work Phone #**

If you already have a MATAplus I.D. Card, please write your I.D. number here: \_\_\_\_\_

**PART II – Emergency Contact Information (must have)**

**First Name:** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Day Phone:** ( ) \_\_\_\_\_ **Evening Phone:** ( ) \_\_\_\_\_

**PART III – Mobility Information (please bring mobility device used most on scheduled interview date)**

**Do you use a mobility device?** Yes  No

**Please check all that apply**

**If yes, which of these mobility/communication aids or equipment do you use to help you get where you need to go? (Please check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> None            | <input type="checkbox"/> Powered wheelchair | <input type="checkbox"/> Powered scooter/cart       |
| <input type="checkbox"/> White Cane      | <input type="checkbox"/> Manual wheelchair  | <input type="checkbox"/> Brace                      |
| <input type="checkbox"/> Cane            | <input type="checkbox"/> Crutches           | <input type="checkbox"/> Oxygen (O2)                |
| <input type="checkbox"/> Walker/Rollator | <input type="checkbox"/> Alphabet Board     | <input type="checkbox"/> Prosthesis (specify) _____ |
| <input type="checkbox"/> Picture Board   | <input type="checkbox"/> Service animal     | <input type="checkbox"/> Other (specify) _____      |

**If you use a wheelchair/scooter is the total combined weight of you and your mobility device more than 600 pounds?** \_\_\_\_\_ **What is the date you were last weighed by your doctor/healthcare provider?** \_\_\_\_\_

**PART VI – Questions about using a fixed-route or trolley**

Are you currently using a MATA fixed-route bus or trolley for transportation?

Yes

No

If yes, how often are you using the bus or trolley? Please explain: \_\_\_\_\_

If yes, please list the routes: \_\_\_\_\_

**Personal Care Attendant (PCA):**

Is there a need for the assistance of a PCA? Yes  No

The ADA has guidelines addressing an applicant's need for assistance regarding that individual's inability to travel independently on either a fixed-route bus or ADA paratransit service or both. The need for assistance MUST relate to the individual's disability AND be beyond what the fixed route or ADA paratransit operator is expected to provide. On fixed-route, the need for assistance pertains only to the actual trip; on ADA paratransit, assistance would apply to both the trip itself and the destination. Check the appropriate box(es) and circle the type of assistance needed for the task.

If you used the fixed-route, would you need:

- Physical or navigational/directional assistance while traveling/at the destination?
- Behavioral assistance while traveling or once reached destination?
- Assistance with daily activities such as handling packages, medications, etc.?
- Assistance reading or counting money?
- Assistance beyond curb-to-curb or destination-to-destination?
- Other \_\_\_\_\_
- Not Applicable

**PART V – Affidavit:**

I verify that all statements are true and correct to the best of my knowledge. I understand that giving false information can disqualify my application and subsequent participation. I authorize MATA to obtain verification of any information presented in this application and obtain essential medical information necessary to determine MATA's Paratransit eligibility. I agree to participate in an in-person interview and functional assessment to determine paratransit eligibility (MATAplus).

Applicant's Signature

Date

**\*\*\*PLEASE READ\*\*\***

**Please bring the most recent medical/diagnostic records or information that verifies your disability related to:**

- Vision/Hearing/Speech Condition
- Developmental/ Mental Condition -- (Voc. Rehab, School IEP & 504 documents accepted)

*Alternate documents from professionals that specialize in those areas may be used instead of an assessment at this time. However, ask the assessment center for additional clarification about how old and the type of an assessment may be accepted.*

## Medical Verification of Disability Form

**\*\*\*PLEASE NOTE\*\*\***

**This Form must be completed in its entirety. Any form with requested information omitted will not be processed and can affect the certification of this applicant.**

**DATE:** \_\_\_\_\_

**Patient (Applicant) Name:** \_\_\_\_\_ **Patient/(Applicant) Date of Birth:** \_\_\_\_\_

Dear Health Care Professional:

You are asked to provide information regarding this individual's disability. The Federal Law is specific regarding ADA paratransit eligibility. The law restricts eligibility to individuals who:

1. because of their disability, cannot board, ride, or disembark from a regular fixed-route bus or;
2. have a specific impairment-related condition, which prevents them from getting to or from a bus stop.

Therefore, the information you provide will help MATA determine your patient's functional and cognitive ability to use public transportation. This Form also helps MATA decide when and under what circumstance (s) the applicant can utilize the fixed-route bus system. All our vehicles are equipped with a wheelchair lift for individuals who need to use a wheelchair or cannot climb stairs. You must be as precise as possible in your evaluation. All information on this Form will be kept confidential and will not be released.

**PLEASE NOTE:** This does not include persons who find it difficult or uncomfortable to get to and from bus stops. In providing information, you should consider only the presence of a disability or health condition and not the applicant's age, lack of reliable transportation, or economic status.

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**Applicant General Health Information:**

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Name of Healthcare Profession or Agency: \_\_\_\_\_

Address of Provider's Office: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_  
Fax Number: \_\_\_\_\_

How long have you been treating the applicant? \_\_\_\_\_

What is the nature of the disability or condition that affects the person's ability to use the regular fixed-route bus system? (check all that apply)

- General Medical Condition
- Bone and Joint Condition
- Brain/Nerves/Muscle Condition
- Heart and Circulatory Condition
- Lung and Breathing Condition

***We recommend submitting the most recent medical/diagnostic records or information that verifies the applicant's disability for the following types of conditions from a specialist for consideration. It may be used instead of an assessment.***

- Vision/Hearing/Speech Condition
- Developmental/ Mental Condition ***(School IEPs & 504 documents accepted)***

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**Status of applicant's/patient's disability:**

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The disability/condition that supports the applicant's case in qualifying for paratransit services is:

- Permanent \_\_\_\_\_
- Temporary \_\_\_\_\_

If the condition is temporary, estimate the applicant's time for a full recovery and the possible length of time paratransit services will be needed before the applicant can resume normal travel/transportation practices. Check below if:

- The applicant's disability or health condition is only temporarily expected to prevent fixed route use, ***or***
- The applicant is newly disabled and expects to improve their functional abilities to allow fixed route use under at least some conditions.

If the condition is permanent, please list the condition (s) and date of onset of the condition below:

**ICD 10/Diagnosis/Disability:**

**Date of Onset:**

1.

2.

3.

**My signature below certifies that the above information is accurate.** *(If the verifier of the applicant's/patient's information for qualification for paratransit service (MATApplus) is not a medical doctor, please provide your area of training/specialization, license number, and state that issued your license to practice within the profession below.)*

\_\_\_\_\_  
\*\* Physician/Other Healthcare Provider\*\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
License Number

\_\_\_\_\_  
State