



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

**PLEASE BRING COMPLETED APPLICATION & MEDICAL VERIFICATION FORM TO:
MATApplus Eligibility Center - 3033 Airways Blvd. - Memphis, TN 38131**

NOTE: Complete all pages of the application.

MATA will process incomplete applications.

Faxed or mailed applications will not be 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. When we have individuals that cannot use fixed-route buses or the trolley, they can be certified for MATApplus. **To be certified, the applicant will need to complete this application and the medical verification form before the in-person interview and functional assessment. The applicant must complete the entire certification process to be deemed eligible MATApplus.** The steps to eligibility certification are as follows:

STEP 1:

- Complete your application (your demographic information and information about your disability)
- Have your Physician/Healthcare Services Provider complete and return **TO YOU** the **Medical Verification of Disability Form**.

STEP 2:

- Once you receive the **Medical Verification of Disability Form**, call the Eligibility Center to schedule your interview and possible functional assessment.
- Show-up at the assessment center for your interview and assessment (please arrive on time).

STEP 3:

- Participate in a face-to-face interview with the MATApplus Compliance Specialist.
- The applicant has a picture taken for their MATApplus I.D. Card, if applicable.
- 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) days following the interview and assessment.

PLEASE COMPLETE THE ENTIRE APPLICATION

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

Application Type (please check one)

Original Certification

Recertification

First Name: _____ **Last Name** _____ **Middle Initial** _____

How do you identify

Male

Female

Other

Date of Birth MM | DD | YYYY _____

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 MATApplus I.D. Card, please write your I.D. number here: _____

PART II – Emergency Contact Information

First Name: _____ **Last Name** _____ **Middle Initial** _____

Relationship: _____

Day Phone: () _____ **Evening Phone:** () _____

PART III – Mobility Information

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)

White Cane Powered wheelchair Powered scooter/cart

Cane Manual wheelchair Brace

Walker Crutches Oxygen

Picture Board Alphabet Board Prosthesis (specify) _____

None Service animal 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 your transportation?

Yes No

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

If yes, please list the routes: _____

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 registration. I authorize MATA to obtain verification of any information presented in this application and to obtain essential medical information necessary for the determination of MATA's Paratransit eligibility. I also agree to submit myself for an in-person interview and functional assessment by MATA for a determination of MATA's Paratransit eligibility (MATAplus).

Applicant's Signature

Date

*****PLEASE READ*****

We recommend the submission of 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 excepted)

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 type of an assessment we will accept.

Client #:

Date application received: _____

Date approved/denied: _____

Approved Denied

For office use only.

MATaplus

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 being 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, which you provide, will assist MATA in determining your patient's functional and cognitive ability to use public transportation. This form also helps MATA in deciding when and under what circumstance (s) the applicant can utilize the fixed route bus system. All of our vehicles are equipped with a wheelchair lift for individuals who need to use a wheelchair or cannot climb stairs. It is essential that you be as precise as possible in your evaluation. All information on this form will be kept strictly 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.

Applicant General Health Information:

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 the submission of 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. May be used instead of an assessment.

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

Status of applicant's/patient's disability:

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 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, list the condition (s) and date of onset of the condition below:

Diagnosis/Disability:	Date of Onset:
1. _____	_____
2. _____	_____
3. _____	_____

Personal Care Attendant (PCA):

Does the applicant (your patient) require 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, the need for assistance would apply to both the trip itself and at the destination. Check the appropriate box(es) and circle what type of assistance is needed for the task.

If the applicant were to use the fixed-route, would they need:

- Physical or navigational assistance to travel two blocks?
- Physical or behavioral assistance while waiting 10 min. for the bus/trolley?
- Physical or directional assistance in getting on or off the bus/trolley?
- Physical or behavioral assistance while riding the bus/trolley?
- Directional assistance regarding - when or where to get off the bus/trolley?
- Other _____
- Not Applicable

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**	License Number	State
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