



Dear Applicant:

We appreciate your interest in Rock Region METRO's Links Paratransit Service. METRO Links is a curb-to-curb demand response service provided to disabled citizens. The enclosed application will determine your eligibility to use METRO Links service.

METRO Links is an ADA paratransit service, required by federal law to provide transportation for disabled residents. METRO Links is an origin to destination, shared-ride service that complements METRO's fixed-route bus services. The service is designed to meet the requirements of the Americans with Disabilities Acts (ADA).

The information obtained in this Americans with Disabilities Acts (ADA) certification process will only be used by Rock Region METRO for the provision of transportation services. This information is kept confidential. The application must be filled out completely and legibly. The enclosed Physician's Verification of Disability Form must be completed by a doctor, licensed health care provider, licensed rehab/social worker or Orientation Mobility Specialist familiar with your disability.

After METRO Links receives your completed application, you may be contacted to schedule an in-person interview to aid in the determination of your eligibility. Upon request, transportation will be provided to you free of charge both to and from the interview site.

If you require any assistance in completing this application, you may call our office at 501-375-9607. You will receive a determination letter within 21 days of submission.

Again, we thank you for your interest in METRO Links Paratransit Service.

901 MAPLE, NORTH LITTLE ROCK, AR 72114
(501) 375-9607 • TDD (501) 375-9608 • FAX (501) 375-6812



If this is a gated community, please provide gate code:

In Case of Emergency Notify:

NAME

RELATIONSHIP

HOME PHONE OR CELL PHONE

WORK PHONE

ADDRESS

CITY

STATE

ZIP CODE

PART II – Information on disability and mobility equipment

How does your disability prevent you from using METRO's fixed route bus service? _____

Is your disability permanent? Yes No

If not, expected duration of your disability? _____ / _____ / _____

Have you ever had a seizure? Yes No

If yes, what type? _____ How often? _____

Are seizures controlled with medication? Yes No



Do you use any of the following mobility aids? (Check all that apply)

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Walker | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Powered Wheelchair | <input type="checkbox"/> Support Cane | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> Powered Scooter | <input type="checkbox"/> White Cane | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Braces | <input type="checkbox"/> Other _____ |

PART III – Questions on using METRO’s fixed route bus service

1. Have you ever used METRO’s fixed route bus service? Yes No

2. Are you able to travel to the nearest bus stop? Yes No

If no, please explain: _____

3. Are you able to handle money? Yes No

If no, please explain: _____

4. Are you able to use railings and handles? Yes No

If no, please explain: _____

5. Are you able to keep balance while seated on a moving bus?

Yes No If no, please explain: _____

6. Are you able to understand bus schedules? Yes No

Understand and follow directions? Yes No

Process information to ride fixed route? Yes No



7. Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons?
- Inability to negotiate hilly terrain
 - Extreme sensitivity to climatic conditions
 - Allergic/Environmental sensitivities
 - Hyper-fatigue, frailty
 - Night blindness
 - Inability to cross busy intersections
 - Inability to climb three 10-inch steps
 - Bus stop too far away
8. Are you able to perform the following functions without supervision?
- a) Find your way between familiar locations?
- Yes No Yes, with training
- b) Signal the bus driver to get off at a familiar stop and get off the bus there?
- Yes No Yes, with training
- c) At a bus stop served by more than one bus route, can you distinguish the correct bus to board and indicate your intention to board?
- Yes No Yes, with training
9. Are you able to perform the following functions without the assistance of another person?
- Travel 200 feet (the length of a city block)
 - Travel 1/4 mile (the length of three city blocks)
10. Is your ability to get from place to place affected by:
- Terrain, such as steep hills, no sidewalks/crosswalks, or other conditions
 - Rain, snow, ice
 - Extreme temperatures of heat or very cold



11. Are you able to wait outside for 10 minutes?
 Yes No
12. Do you have trouble standing for more than 15 minutes?
 Yes No
13. Are you able to cross the street of a busy intersection by yourself?
 Yes No
14. If travel training were available, would you be interested in participating? Yes No
15. Please read the following statements and check those which best describe what you believe is your ability to use a METRO bus without assistance. You may select more than one.
 - I can use the METRO bus for some trips, but not at other times because there are barriers that prevent me from using the system.
 - I use the METRO bus service frequently.
 - I have difficulty understanding and remembering all of the things that I would have to do to find my way to and from the bus.
 - I believe I could learn to ride the bus, if someone taught me.
 - I have a visual disability, which prevents me from getting to and from the bus, even with training.
 - The severity of my disability can change from day to day. I can ride the bus only when I am feeling well.
 - I can never use the bus by myself.



I can get to and from the bus if the distance is not too great, and the route is barrier-free.

I am not able to use the METRO bus for other reasons.

(Please explain): _____

16. List three of your most frequent destinations, and how you get there?

Destination	Frequency of Travel	How do you get there now?
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART IV – Please initial all of the following statements indicating you have read and understand each statement.

I understand my rights and responsibilities for METRO Links service and they are:

- _____ 1. METRO Links service is public transportation, and I will be sharing rides with other passengers.
- _____ 2. METRO Links does not provide emergency service.
- _____ 3. I must show my METRO Links ID and pay the fare each time I ride.
- _____ 4. Three “No Shows” in 30 days could result in suspension of service.
- _____ 5. I must be present and ready to board the vehicle within my 30-minute window pick-up time.



- _____ 6. I am only allowed to carry three (3) grocery bags, or similarly sized packages on board.
- _____ 7. Wheelchair lifts can accommodate up to 600 lbs, and 30 inches in width. I understand the combined weight of me, my wheelchair, and accessories must weigh less then 600 lbs. I also understand the width of my wheelchair cannot exceed 30 inches.
- _____ 8. METRO Links reserves the right to require a personal care attendant (PCA) at the time of pick-up. If I am required to have a PCA at the time of pickup, and I do not have one, I will be unable to ride.

I certify the information provided in this application is accurate. I understand that false information may result in the denial or termination of METRO Links service. I further understand that all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform those services.

APPLICANT'S SIGNATURE

DATE

**If someone else is completing this application or has assisted the applicant, that person must complete the following:

NAME

RELATIONSHIP

SIGNATURE

DATE

HOME PHONE

WORK PHONE

CELL PHONE



METRO Links Paratransit Service Physician Verification of Disability Form

*****Please Note*****

This form must be filled out in its entirety. Incomplete forms will not be processed and will be returned to the patient.

DATE _____

PATIENT NAME _____

DOB _____

The person named above is **currently being treated** or **was formerly treated by me.** The person has informed me of his/her intent to apply for Rock Region METRO Links service. The information provided in this form is intended to verify any medical/health conditions that prevent the applicant from using METRO's fixed route bus service.

- Please check one:
- _____ Physician
 - _____ Licensed Healthcare Provider
 - _____ Licensed Rehab/Social Worker
 - _____ Orientation Mobility Specialist

Medical diagnosis and explanation of condition causing disability.



Disability Status (Select One):

- Patient will be temporarily disabled for _____ months.
- Patient is considered permanently disabled.

Does the disability prevent the applicant from utilizing the METRO fixed route services (regular bus service)? If yes, please describe in detail.

Can the applicant walk or wheel 1/4 mile (3 blocks) without the assistance of another person? Yes No

Can the applicant climb three 10-inch steps with assistance? Yes No

Can the applicant wait outside without support for 15 minutes?
 Yes No

Is the applicant on dialysis? Yes No

Does the applicant have a hearing impairment? Yes No

Is the applicant able to recognize a destination or landmark? Yes No

Is the applicant able to give addresses and phone numbers upon request?
 Yes No

Is the applicant able to deal with unexpected situations or unexpected changes in routine? Yes No



Is the applicant able to ask for, understand, and follow directions?

Yes No

Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities? Yes No

Does the applicant require a personal care attendant? Yes No

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

NAME (Please Print)

OFFICE PHONE NUMBER

OFFICE STREET ADDRESS

CITY

STATE

ZIP CODE

STATE LICENSE NUMBER

(Complete if Applicable - MUST BE CURRENT)

SIGNATURE

DATE