755 International Blvd., Brownsville, TX 78520 Phone#956-541-4881

ADA PARATRANSIT ELIGIBILITY & RECERTIFICATION APPLICATION

(Solicitud de Eligibilidad y Renovación para el Servicio de Paratránsito)

This form must be filled out completely. Please print.

(Esta solicitud debe ser llenada totalmente. Favor de escribir en letra de molde)

☐ **1st time application** (solicitud por primera vez) ☐ **Recertification** (renovación)

General Information (Información General)

Name (Nombre):	MiddleInitial (Inicial de su segundo Nombre):	Last Name (Apellido):
Birth Date (Fecha De Nacimiento):	Address (Domicilio):	
City (Ciudad):	State (Estado):	Zip Code (Código Postal):
Home Phone # (# de Teléfono de Su casa)	Work Phone # (# de teléfono de su trabajo):	Alternative Phone # (Otro #):

In what language do you prefer all future communication (letters, phone calls, brochures, etc)?
¿En que idioma prefiere que nos comuniquemos con usted (cartas, llamadas de teléfono, folletos, etc?

❑ English (Inglés) ❑ Spanish (Español)

Disability information (Informacion sobre su discapacidad)

What is the disability that prevents you from using BMetro fixed route service? Please explain and give any information that BMetro may need to be aware about your disability? ¿Cual es la discapacidad que le impide usar el servico de la ruta regular de **BMetro**? Favor de explicar, anote toda información que usted crea que BUS deba de saber en relación a su discapacidad.

Is this condition temporary? If you answered yes, duration will be until what date?

¿Esta condición es temporal? Si contesto que si,¿ hasta que fecha?

How this disability prevents you from using fixed route services (Regular city buses)? Please explain completely. If necessary, continue on a separate sheet.
¿Como es que su discapacidad le impide usar el servicio de ruta regular (autobús de uso general)? Favor de explicar completamente. Use otra hoja si es necesario.)

Do you use any of the following mobility aids? (Check all that apply)
¿Usa usted alguno de los siguientes tipos de ayuda para moverse? (Señale todos los que aplican)

❑ Manual Wheel Chair (Silla de Ruedas Manual) ❑ Powered Wheel Chair(Silla de Ruedas Eléctrica)
❑ Power Scooter (Silla de Tres Ruedas) ❑ Walking Cane (Bastón) ❑ Crutches (Muletas)
❑ Personal Care Assistant (Asistente Personal) ❑ Service Animal (Animal de Servicio)
❑ Walker (Andador) ❑ Other (Otro)_____

If you use an oversize wheelchair or scooter, what is the size:
Si usted usa una silla de ruedas más grande que la manual o una silla de tres ruedas, cual es la medida de:

Length/ Largo: _____ inches Width/Ancho: _____ inches

Does the total weight of your wheelchair or scooter and yourself exceed 600 pounds?
¿Pesa su su silla de ruedas ó silla de tres ruedas con usted encima más de 600 libras/273 kilos?

❑ Yes (Si) ❑ No (No)

Will a Personal Care Attendant need to travel with you?
¿Necesita que un Asistente Personal viaje con usted? ❑ Yes (Si) ❑ No (No)

If yes, when? Si contesto si, ¿cuándo? ❑ Always (Siempre) ❑ Sometimes (A Veces)

****Please note that BMetro does not provide Personal Care Attendants****
Tenga en cuenta que BMetro no provee Asistentes Personales

Please answer the following questions:
Favor de contestar las siguientes preguntas:

Can you travel ½ block without the assistance of another person?
¿Puede usted caminar ½ cuadra sin la ayuda de otra persona?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

Can you travel 200 feet without the assistance of another person?

¿Puede usted caminar 200 pies sin la ayuda de otra persona?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

Can you travel ¼ mile without the assistance of another person?
¿Puede usted caminar ¼ de milla sin la ayuda de otra persona?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

Can you travel ½ mile without the assistance of another person?
¿Puede usted caminar ½ milla sin la ayuda de otra persona?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

Can you travel ¾ mile without the assistance of another person?
¿Puede usted caminar ¾ de milla sin la ayuda de otra persona?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

Can you climb three 12 inch steps without assistance?
¿Puede usted subir tres escalones de 30 centimetros (12 pulgadas) sin ayuda?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

Can you wait outside without support for 10 minutes?
¿Puede usted esperar en el exterior sin asistencia por 10 minutos?

❑ Yes (Si) ❑ No (No) ❑ Sometimes (A Veces)

IN CASE OF EMERGENCY BMetro may contact (En Caso de emergencia BMetro Puede llamar a)			
Name (Nombre):	Relationship (Relación):	Phone # (# teléfono):	Alternative #(other #):

Authorization to Release Information (Autorización para darInformación)

Taking into consideration the severity of your disability it may be necessary for you to designate an individual with whom BMetro may maintain communication in reference to your application. If you consider necessary to designate an individual please complete the section below. Please keep in mind that BMetro will only provide information about your application and/or eligibility status to the individual that you have designated. You may change the designated individual(s) at any time, as long as you notify BMetro in writing.

Tomando en consideración la severidad de su discapacidad es posible que usted necesite que

alguien mas aparte de usted mantega comunicación con BMetro en referente a su solicitud. Si usted desea asignar a alguna persona (s), favor de hacerlo en la siguiente sección. Favor de tener en mente que BMetro solamente le proveera información sobre su solicitud y/o estatus de eligibilidad a la persona(s) que usted asigne. Usted podrá cambiar a la persona(s) asignada(s) cuando usted quiera, solamente que necesitara notificar a BMetro por escrito.

Name (Nombre):	Relationship (Relación):	Phone # (# teléfono):	Alternative #(otro #):
Name (Nombre):	Relationship (Relación):	Phone # (# teléfono):	Alternative #(otro #):

Applicant's Signature (Firma del Solicitante)

I understand that the information contained in this application will be kept confidential and will be shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this application form is true and correct.

Yo entiendo que la información contenida en esta solicitud es confidencial y será solamente compartida con profesionales involucrados en evaluar mi eligibilidad para el programa. Yo certifico, que a mi mejor conocimiento, la información en esta solicitud es verdadera y correcta.

Applicant's Signature **Date**
(Firma del Solicitante) _____ (Fecha) _____

If someone else other than the applicant completed this application on behalf of the applicant, that person must complete this section:
Si alguien que no sea el solicitante llenó esta solicitud, favor de llenar esta sección:

Name and Title
(Nombre y Título):_____

Agency/Relationship to Applicant
(Agencia/Relación al solicitante) :_____

Address (Domicilio): _____

Phone # (# de teléfono)_____

Medical information release authorization

In order for Brownsville Metro to evaluate your request, it may be necessary to contact a medical professional to confirm the information that you have provided. Please complete the following information and authorization form.

Para que Brownsvile Metro (BMetro) evalúe su solicitud, podría ser necesario contactar a un profesional médico para confirmar la información que usted ha proveeido en esta solicitud. Favor de llenar la siguiente sección de autorización para poder obtener información de su profesional médico.

The following health care professional is familiar with my disability and is authorized to provide Brownsville Metro all information in reference to my disability and to verify to BMetro all the information provided in my application for ADA Paratransit Services.

El siguiente profesional del cuidado de la salud tiene conocimiento de mi discapacidad y yo lo (a) autorizo a proveer a Brownsville Metro toda información en referencia a mi discapacidad y a que verifique la información que yo proveí en la Solicitud para el Servicio de Paratransito.

Medical Provider (Nombre de su provedor medico):	Initial (Inicial):	Last Name (Apellido):	
Address (Dirección):	City (Ciudad):	State (Estado):	Zip Code (Código Postal):
Phone # (# de Teléfono)	Fax # (# de Fax)	Alternative Phone # (Otro #):	

Name of Applicant (Print)
Nombre del Solicitante (en letra de molde)_____

Applicant's Signature _____ **Date** _____
(Firma del Solicitante)

STOP ALTO

THE NEXT SECTION NEEDS TO BE COMPLETED BY YOUR MEDICAL PROFESSIONAL.
LA SIGUIENTE PARTE DE ESTA SOLICITUD DEBE SER LLENADA POR SU PROFESIONAL MEDICO.

REQUEST FOR PROFESSIONAL VERFICATION

Dear Medical Professional:

The applicant named in this application package is requesting ADA Paratransit Services. Therefore, Brownsville Metro (BMetro) is requesting your assistance in verifying that the information provided in this application package is correct.

Please review the eligibility criteria described below and then complete the *Request for Professional Verification* form that is included in this package. If you may have any questions, please contact the BMetro office at (956) 541-4881.

The applicant named in this application package has completed the *Medical Information Release Authorization* section; and has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transportation services. Federal law requires that Brownsville Metro provide ADA Paratransit Services to individuals who cannot utilize available accessible fixed route services (regular bus). Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location, or riding on a fixed route system more difficult or less comfortable, are not reasons for ADA Paratransit eligibility. The information you provide will allow us to make an appropriate evaluation of the request and its application to specific trip requests. Thank you for your cooperation in this matter.

Capacity in which you know the applicant:

Medical diagnosis of condition causing disability:

Is this condition temporary? If you answered yes, duration will be until?

How does this condition affect the individual's ability to use BMetro fixed route service (regular bus)?

Does this individual require the use of any of the following mobility aids? Check all that apply.

❑ Manual Wheel Chair ❑ Powered Wheel Chair ❑ Power Scooter ❑ Walking Cane

❑ Crutches ❑ Personal Care Assistant ❑ Service Animal ❑ Walker ❑ Other_____

If the individual has a disability affecting mobility, is the person able to:

Can this individual travel ½ block without the assistance of another person?

❑ Yes ❑ No ❑ Sometimes

Can this individual travel 200 feet without the assistance of another person?

❑ Yes ❑ No ❑ Sometimes

Can this individual travel ¼ mile without the assistance of another person?

❑ Yes ❑ No ❑ Sometimes

Can this individual travel ½ mile without the assistance of another person?

❑ Yes ❑ No ❑ Sometimes

Can this individual travel ¾ mile without the assistance of another person?

❑ Yes ❑ No ❑ Sometimes

Can this individual climb three 12 inch steps without assistance?

❑ Yes ❑ No ❑ Sometimes

Can this individual wait outside without support for 10 minutes?

❑ Yes ❑ No ❑ Sometimes

Can this individual travel in extreme hot/cold weather?

❑ Yes ❑ No ❑ Sometimes

If this individual has a visual impairment please complete the following

Visual acuity with best correction: Right eye_____ Left eye _____ Both eyes_____

Visual fields: Right eye_____ Left eye _____ Both eyes_____

If this individual has a cognitive disability is he or she able to do the following?

Give address and telephone numbers upon request?

❑ Yes ❑ No ❑ Sometimes

Recognize a destination or landmark?

❑ Yes ❑ No ❑ Sometimes

Deal with unexpected situations or changes in routine?

❑ Yes ❑ No ❑ Sometimes

Ask for, understand and follow directions?

❑ Yes ❑ No ❑ Sometimes

Safely and effectively travel through crowded and/or complex facilities?

❑ Yes ❑ No ❑ Sometimes

Is there any other effect of the disability of which Brownsville Metro should be aware? If so, please describe. (If necessary, continue on separate sheet).

Medical Professional Completing Request for Professional Verification

Name and Credentials:

Office Address:

Office Phone Number: **Fax Number:**

Medical Professional Signature: **Date:**

FOR BMETRO OFFICE USE ONLY

Date Application was received:

Date Application: Approved ❑ Denied ❑ __ /__ /__

Assigned ID#:

Reason for Denial: