CCTA
CENTRAL COUNTY
TRANSPORTATION AUTHORITY

530 North Rose Street
Kalamazoo, Michigan 490007
Telephone: 269-337-8446
Fax: 269-337-8211
www.kmetro .com

KALAMAZOO METRO TRANSIT
METRO COUNTY CONNECT CERTIFICATION APPLICATION

PROFESSIONAL VERIFICATION OF FUNCTIONAL LIMITATION AFFECTING MOBILITY USED TO DETERMINE ADA COMPARABLE PARATRANSIT ELIGIBILITY

To: _____

_____

_____

Your patient/client _____ has submitted an application for ADA Comparable Paratransit Service to Kalamazoo Metro Transit and has indicated that you can provide information regarding his/her disability. Federal law requires that Kalamazoo Metro Transit provide paratransit services accessible to persons who cannot use our fixed-route accessible bus service.

Please take a moment to fill out the following questions regarding your patient's mobility capabilities, and return this questionnaire by _____ to Kalamazoo Metro Transit, Attn: Metro County Connect Coordinator, 530 N. Rose Street, Kalamazoo, MI 49007-3638, or fax via (269) 337-8211. An authorization from your patient/client is included with this request.

The information you provide will be used with other information to determine your patient's eligibility for our paratransit service. Please note that we are not asking you to make an eligibility decision, but only to provide us with information about this individual's disabilities.

Please complete each question with as much detail as possible; this will assist in determining the applicant's eligibility. All information will be kept confidential.

Thank you for your prompt attention to this request. If you have any questions regarding this part of the ADA Paratransit application process, please do not hesitate to contact me at (269) 337-8477 or congdonr@kmetro.com

Sincerely,

Central County Transportation Authority

Richard G. Congdon
Metro County Connect Coordinator

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Name of Patient/Client: _____

Name of Professional: _____

Health Organization: _____

Street Address: _____

City/State/ZIP: _____

Telephone Number: _____

Please specify the applicant's disability (formal diagnosis):

_____

_____

_____

How does the applicant's physical or cognitive condition(s) cause functional limitations that adversely affect his/her mobility and prevents the applicant from using fixed-route bus service? **Please Be Specific**

_____

_____

_____

_____

_____

Does this person require a Personal Care Attendant in order to use public transportation?

_____ Yes _____ No

If yes, please describe why: _____

_____

_____

Metro County Connect *Access* is a curb-to-curb service, but also offers door-to-door service to passengers who require additional assistance due to their disability. Does your client/patient require door-to-door service in order to use public transportation?

_____ Yes _____ No

If yes, please describe why: _____

_____

_____

In order that your client's/patient's condition can be properly evaluated, please indicate his/her ability with regard to the following:

How many city blocks can your client/patient walk without assistance? _____ blocks

If your client/patient uses a mobility device, how many city blocks can he/she travel using this device? _____ blocks

How many 12-inch high steps can your client/patient climb without assistance? _____ steps

How long can your client/patient stand and wait without support or sit in an outdoor environment? _____ minutes

Is the applicant able to:

Use the fixed-route bus independently?	_____ Yes	_____ No
Read information signs?	_____ Yes	_____ No
Know where to get on/off the fixed-route bus?	_____ Yes	_____ No
Ask for, understand and follow spoken directions?	_____ Yes	_____ No
Recognize a destination or landmark?	_____ Yes	_____ No
Communicate addresses, destinations or phone numbers?	_____ Yes	_____ No

If you answered no to any questions above, please explain:

_____

_____

_____

_____

Please indicate any other limitations that may affect your client's/patient's mobility:

_____

_____

Is your client's/patient's health condition or transportation disability temporary?

_____ Yes, I expect it to last for another _____ months
_____ No, it is a permanent condition
_____ I do not know

Has your client/patient had this health condition or transportation disability for more than one year?

_____ Yes
_____ No
_____ I do not know

Please indicate below any additional information you can provide that will assist Metro County Connect in determining your client's/patient's eligibility for paratransit service.

_____

_____

_____

_____

_____

Signature of Professional **Date**

Thank you for taking the time to complete this verification for your client/patient.

I authorize the release of all personal and medical information for my application for Metro County Connect paratransit service. All information will be kept confidential.

_____

Applicant Signature **Date**