Application for
MetroAccess Door-to-Door Paratransit Service
For People with Disabilities

DO NOT MAIL OR FAX APPLICATION

Transit Accessibility Center
600 5th Street, NW
Washington, DC 20001
(Between Chinatown/Gallery Place and Judiciary Square Metro Stations)
(202) 962-2700 & select option #5
TTY (202) 962-2033

All Assessments are by Appointment Only

Thank you for your interest in Metro services for people with disabilities. The following services are available based on Metro's determination of your eligibility:

(A) Reduced Fare Program for People with Disabilities – Eligible people with disabilities travel on accessible Metrobus and Metrorail for half the regular (rush hour) fare at all times. This program is available for people with disabilities who use the accessible Metrobus and Metrorail system as their primary travel option. For more information on the Reduced Fare program or to obtain an application please visit our website at http://www.wmata.com/accessibility/metroaccess_eligibility.cfm under the section titled "How do I get a Metro Disability ID Card?" or call (202) 962-2700 and select option 1 from the phone menu.

(B) MetroAccess – Door-to-door, shared ride public paratransit service for people with disabilities who are unable to use regular accessible Metrobus and Metrorail public transportation for some or all of their public transportation due to a disability. The Americans with Disabilities Act (ADA) outlines specific criteria to determine eligibility for paratransit service and an application an in-person assessment is required. MetroAccess operates throughout the metropolitan area where there is regular bus and/or rail service. Service is provided in Washington, DC; Montgomery County and Prince George's County in Maryland; Arlington County, Fairfax County, City of Alexandria, City of Fairfax, and City of Falls Church in Virginia.

To apply for this service you and your healthcare provider must complete this application. Please read and follow the instructions on page 2.

Instructions

Step 1: Read the entire application and complete Part A.

Step 2: Read **Accessible Transportation Options for People with Disabilities and Senior Citizens in the Washington, DC Metropolitan Area,** included with this application packet or also available at http://www.wmata.com/accessibility/doc/Accessible_Transportation_Options.pdf

Step 3: Take the entire application to a **healthcare provider holding active licensure or credentials in the area of your disability** to complete Part B. One of the following health care providers must certify the application: Physician, Physician's Assistant, Certified Nurse Practitioner, Optometrist (visual disabilities only), Podiatrist (disabilities of the foot and ankle only) or, Licensed Clinical Psychologist (Psychiatric disabilities only). It is your responsibility to ensure the original signed and completed application is received by the Metro Transit Accessibility Center on the day of your appointment.

Step 4: Upon completion of the application, call 202-962-2700 and select option 5, (TTY 202-962-2033) to conduct a pre-assessment interview. At that time, a determination will be made as to the type of appointment and/or assessment that will be required, and an appointment will be made for you. **Please have your completed application at hand** when you call. Also ensure you contact the office within 60 days of the date of the healthcare provider's signature. Applications more than 60 days old will not be accepted. **You will be instructed to *bring your completed original* application with you to the appointment. *Do not mail or fax the application. NOTE: We require 24 hours notice if you need to cancel your appointment, except in case of a verified emergency. If you miss or cancel 2 appointments you will be required to complete a new application and be required to wait 120 days to reapply.***

Copies, faxes, and scans *will not* be accepted. Applications with missing information will not be accepted and will be returned to the applicant without processing. Applications that are mailed will be returned to the applicant with instructions to contact the Transit Accessibility Center.

Step 5: Metro will determine your eligibility based on how your disability impacts your functional abilities to use the accessible Metrobus and Metrorail public transportation system. Financial need is not a criterion for MetroAccess eligibility. All assessments take place at the Metro Transit Accessibility Center. If you use a mobility aid, please bring it with you to the assessment. If transportation is needed, advise the Metro Transit Accessibility Center representative at the time of your telephone interview.

If you have questions or need additional information, please contact the Metro Transit Accessibility Center at 202-962-2700 and select option 5, TTY 202-962-2033 or e-mail eligibility@wmata.com. **Please do not bring children to the appointment unless the child is the applicant**. Please note that the minimum age to apply for the service is 5 years old. The office is open Monday, Wednesday - Friday from 8:00 AM - 4:00 PM, and Tuesday, 8:00 AM to 2:30 PM. Hours are subject to change without notice so Please call in advance. Phone lines open at 8:30 on all days.

❑ **I am a current MetroAccess customer. MetroAccess ID Card # _____**

❑ **I am a current Reduced Fare customer. Reduced Fare ID Card # _____**

❑ **I have access to the internet and/or have an email account.**

Part A: APPLICANT INFORMATION AND RELEASE (Copies, faxes or scans will not be accepted)

Last Name_____ First Name_____ Middle Initial _____

Street Address: **Apartment #:**

City, State, Zip: **County or City:**

Gender: ❑Male ❑Female **Date of Birth: ___/_____/_____ E-mail:_____**

Primary phone number: ( ) _____ ❑Home ❑Cell Phone ❑Work

Secondary phone number: ( ) _____ ❑Home ❑Cell Phone ❑Work

In case of an emergency, who should be notified?

Name:

Relationship: **Phone: ( ) _____**

Mobility Devices: Do you require the use of a mobility device when traveling? ❑ No ❑Yes

Check all that apply: ❑Manual Wheelchair ❑ Support Cane ❑Portable Oxygen

❑Power Wheelchair or Scooter up to 48" x 30" and no more than 800 pounds when occupied

❑Crutches ❑Walker ❑White Cane(for visually impaired) ❑Other: _____

Do you use a service animal? ❑No ❑Yes ❑Sometimes If yes, please describe the type of animal and what service(s) the animal was trained to perform:

I certify that all information contained in part A of this application were completed by me or my appointed representative and are true.

Original Signature of Applicant: _____ Date:_____
(Under 18, Signature of Parent or Guardian)

AUTHORIZATION TO HELP ME APPLY FOR METROACCESS SERVICES

Please complete the authorization below if you are providing legal authority to another party to complete this application and act as your agent in the processing of this application.

***** This form is only to be used when an applicant is not able to otherwise give consent for assistance and information sharing.***

Applicant's Name_____

Applicant's Address_____

_____

I would like to apply for MetroAccess door to door paratransit service.
I am appointing _____to help me apply for MetroAccess service. For this purpose only, he or she has the authority to act on my behalf, including scheduling appointments, completing paperwork, and providing information about me to WMATA (Metro), so long as it relates to my application for MetroAccess service. Metro may release any information it has about me upon request, to this person, including health care information, so long as it relates to my application for services. For this purpose only, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA) and is entitled to request, receive, and review protected health information: any information, oral or written, regarding my physical or mental health, including but not limited to medical and hospital records, and other protected health information. My agent may also consent to disclosure of this information.

This agreement expires: (Select one from options below.)

_____ At the end of my appointment on _____; or

_____ At the end of my MetroAccess certification process; or

_____ At the end of my MetroAccess certification and any applicable appeal process.

In any event, this agreement would expire no later than one year from when it is signed. I can cancel this agreement at any time by telling the person and calling Metro to inform them that this authorization is no longer valid.

Signature Date

Printed Name

I, _____, agree to help _____ with
(Agent's Name) **(Applicant's Name)**
his/her application for MetroAccess services. Either I, or another person from my organization, will come with the applicant to their eligibility appointment and assist him/her.

Signature Date

Printed Name

Part B: HEALTH CARE PROVIDER CERTIFICATION

A healthcare provider holding active licensure or credentials in the area of the applicant's disability or the applicant's primary care provider as outlined on page 2 must complete Part B.

Your patient has requested eligibility for MetroAccess services. MetroAccess is a door to door, shared ride paratransit service for people whose disability(ies) prevent them from riding the fixed route accessible system, all or part of the time. As the applicant's healthcare provider you are uniquely qualified to clarify his or her functional abilities and limitations to ride the Metro's accessible bus and rail system. In order to determine this applicant's functional abilities we require that **you the healthcare provider not the applicant** complete and certify **all** of the following sections. Please detail how the applicant's disability(ies) impact their ability to board, navigate and travel independently on the accessible fixed route system. Please be as specific as possible

Applicant's HIPAA Authorization:

I _____authorize the healthcare provider completing this application to release to the Washington Metropolitan Area Transit Authority (Metro) any protected health information about my disability in order to verify my eligibility for Metro Services for People with Disabilities. I also authorize the release of further information should it be needed for this application for a period of 60 days from the date of my signature on part A of this application.

_____ (Applicant's name) is being referred for a brief functional assessment to determine eligibility for Metro services for people with disabilities.

1. **Name of Health Care Provider**: (Please print)_____

2. **Phone**: **( ) _____**

3. **License Number/State Issued**: **_____**

4. **Street Address & Suite #:** _____

5. **City, State, Zip**: _____

6. **Specialization**: _____

7. **Written Diagnosis (es) and ICD-9CM and/or DSM Code(s):** _____

_____

8. **HYPERTENSION:** Eligibility for service is determined by a functional assessment, which is conducted by a certified/licensed therapist with the Transit Accessibility Center. Applicants may be required to walk/travel up to 1/2 mile. In order to ensure the safety of the applicant, a blood pressure (B/P) reading is taken prior to starting the assessment. If the applicant's resting B/P is

160/100 or higher, the assessment will be suspended pending certification by the health care provider that the applicant can complete the assessment. If you are currently treating the applicant for hypertension and certify that he/she is cleared to complete the functional assessment, we may proceed without referring the applicant back to you for evaluation and certification.

9. Are you currently treating this applicant for Hypertension? ❑No ❑Yes

10. Applicant can complete the assessment as described above if B/P *does not go above* a reading of:_____

11. If applicant has a seizure disorder or epilepsy have they had a tonic-clonic seizure within the past 4 months?

❑No ❑Yes ❑N/A

12. Does the applicant require a Personal Care Attendant (PCA) when traveling on public transportation?

❑No ❑Yes

13. Does the applicant require any of the following mobility aids listed in question 14?

❑No ❑Yes

14. Check all that apply: ❑Manual Wheelchair ❑Support Cane ❑Portable Oxygen

❑Power Wheelchair or Scooter ❑Crutches ❑Walker ❑White Cane (visually impaired)
❑Other: _____

15. What is the expected duration of the disability? (Please initial appropriate box)

_____Short-Term: Conditions that last at least 90 days, but are likely to improve within one year.

_____Long-Term: Conditions with absolutely little expectation of improvement

16. Does this applicant's disability(ies) prevent him/her from independently using the accessible Metrobus and Metrorail system?

❑No ❑Yes

If yes, HOW does the disability or health condition impact the applicant's ability to travel independently from one location to another on the accessible Metrobus and Metrorail system?

_____
_____
_____
_____
_____

17. If this applicant is currently on medication(s), will the side effects of this significantly reduce or hinder his/her ability to independently ride the accessible Metrobus and Metrorail system?

❑No ❑Yes ❑N/A

If you selected ***yes*** for this question, please explain how the side effects would hinder this applicant's ability to use the accessible fixed route bus and rail system:

_____

_____

_____

_____

ENVIRONMENTAL ISSUES THAT AFFECT THE APPLICANT

Based on the applicant's disability(ies), please tell us if following environmental factors affect his/her ability to ride Metro's accessible bus and rail system.

18. Would extremes in temperature affect this applicant's ability to ride the accessible Metrobus or Metrorail?

❑ No ❑Yes

If yes, please explain the effect and the extent of the limitation(s)

_____

_____

_____

19. Would ice and/or snow affect this applicant's ability to ride accessible Metrobus or Metrorail system?

❑No ❑Yes

If yes please explain the effect and the extent of the limitation(s)

_____

_____

_____

20. Would poor air quality affect this applicant's ability to ride Metrobus or Metrorail?

❑Yes ❑No If yes please explain the effect and the extent of the limitation(s). **NOTE:** If applicant suffers from Asthma, please indicate if the applicant has been on systemic medication for the immediate past 6 months OR has been required to use fast acting inhalers for three or more episodes per week for the immediate past six months

_____

_____

_____

21. In your medical opinion what other factors related to the applicant's disability(ies) affect his/her ability to ride the accessible Metrobus or Metrorail?

_____
_____
_____
_____

HEALTH CARE PROVIDER SIGNATURE PAGE

I certify that **I have completed** the questions in Part B and that the information provided is correct.

Original Signature of Physician/Healthcare Provider: _____
(Note: Must be original hand signature, not signature stamp)

Printed Name_____Date: _____

False certification may be reported to the licensing agency under District of Columbia Code Annotated, Section 2-3305.15, Code of Virginia 54. 1-2915, or Maryland Health Occupations Code Annotated 14-404 or appropriate code for state of license. Metro reserves the right to: (1) verify the validity of the license of the health care provider providing the certification, (2) make the final determination on an applicant's eligibility for Metro services for people with disabilities, and (3) retain a copy of this application.