Metro Area Public Transit System
123 S. Main Street
Joplin, Missouri 64801
417-626-8607
MAPS-Dispatch-Center@joplinmo.org

Request for Certification of ADA Para-Transit Eligibility The information obtained in this certification process will only be used by Metro Area Public Transit System for the sole provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

Name (First, Middle, Last) _____

Date of Birth (MM/DD/YY) _____ Male_____ Female_____

Physical Address _____ Apt # _____

City: _____ State _____ Zip _____

Daytime Phone #: (____) _____ Evening Phone #: (____) _____

Mailing Address (if different from physical address):

Address _____ Apt # _____

City: _____ State _____ Zip _____

In case of emergency, whom should we contact:

Name: _____

Relationship: _____

Phone #: (____) _____

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Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.

1. Which disability or health related condition(s) PREVENT you from using the Fixed Route Bus Service without the help of another person?

_____

_____

_____

_____

_____

2. Briefly explain HOW your condition prevents you from using the Fixed Route Bus Service without the help of another person.

_____

_____

_____

_____

_____

3. When did you first experience the conditions, you described above?

____0-1 year ago ____1-5 years ago ____Longer than 5 years ago

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4. Do the conditions you described change from day to day in a way that affects your ability to use the Fixed Route Bus Service?

____Yes, good on some days, bad on others. ____No, it doesn't change. ____I don't know.

5. Are the conditions you described:

____Permanent ____Temporary ____Don't Know

If temporary, how long do you expect the condition to continue? Please explain.

_____

_____

_____

_____

_____

6. Do you use any of the following mobility aids or specialized equipment?

(Check all that apply):

____Cane Power ____Wheelchair ____Communication Devices

____White Cane ____Service Animal ____Walker

____Power Scooter ____Crutches ____Manual Wheelchair

____Leg Braces ____Portable Oxygen ____Other: _____

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If you use a wheelchair, what are the physical dimensions of the chair including foot or head extensions (in inches)? _____ Wide _____ High _____ Long

7. Are you legally blind? ____Yes ____No

8. Do you have limited vision? ____Yes ____No

9. Please check the box that best describes your current living situation:

____24-hour care or Skilled Nursing Facility

____Assisted Living facility

____I receive assistance from someone that comes to my home to help with daily living activities

____I live with family members who help me

____I live independently (without the assistance of another person)

10. How many city blocks can you travel with your usual mobility aid and without the help of another person? _____

11. Which of the following statements best describes you if you had to wait outside for a ride? (Check only one response.):

____I could wait by myself for ten to fifteen minutes

____I could wait by myself for ten to fifteen minutes only if I had a seat and shelter

____I would need someone to wait with me because:

_____

_____

_____

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12. How do you currently travel to your frequent destinations?

(Check all that apply):

____Buses ____Drive myself ____Taxi (On-demand service)

____Someone drives me Other: _____

13. Do you travel with the help of another person?

____Always ____Sometimes ____Never

If “Always” or “Sometimes”, what type of help are you provided with?

_____

_____

_____

14. Would you be able to get to and from the public transit stop nearest your home?

____Yes ____No ____Sometimes

If “No” or “Sometimes”, please explain?

_____

_____

15. Would you be able to grasp handles or railings, coins or tickets while boarding or exiting a transit vehicle?

____Yes ____No ____Sometimes ____Don’t know, never tried it.

If “No” or “Sometimes”, please explain?

_____

_____

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16. Would you be able to maintain balance and tolerate movement of a public transit vehicle when seated?

____Yes ____No ____Sometimes ____Don't know, never tried it.

If "No" or "Sometimes", please explain?

_____

_____

17. Would you be able to get on or off a public transit bus if it has either a lift or a ramp?

____Yes ____No ____Sometimes ____Don't know, never tried it.

If "No" or "Sometimes", please explain?

_____

_____

_____

18. Please add any other information that you would like us to know.

_____

_____

_____

_____

_____

Applicant Signature: _____Date: _____

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A Signed letter from a medical professional must be included. The letter must:

-Be on medical facility letterhead

-Include applicant's name, date of birth, and diagnosis.

-State how the disability affects fixed-route usage

-Be signed by a qualifying medical provider

Did someone help you complete this form? _____ YES _____ NO

If yes, Name: _____

Relationship: _____ Phone: _____

**Have you answered all the questions and provided explanations where required? **

**INCOMPLETE APPLICATIONS WILL BE RETURNED AND WILL DELAY THE APPROVAL PROCESS. **

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Medical Verification Form for ADA Paratransit Eligibility Determination.

Please take this form to medical provider

Section 1: Applicant Information (To be completed by applicant)

Full Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Section 2: Medical Professional Verification (To be completed by provider)

Please take to your healthcare provider to fill out this form.

This form is to assist in determining the applicant's functional ability to use fixed-route transit, not to identify a medical diagnosis or condition unless directly relevant.

Does the applicant have a physical, cognitive, or mental health condition that functionally prevents them from using regular fixed-route buses independently?

_____ Yes _____ No _____ Sometimes

If yes or sometimes, please indicate how the disability affects transit use (check all the apply)

___ Cannot walk to/from a bus stop

___ Cannot navigate the transit system independently

___ Cannot recognize destinations or remember routes

___ Cannot board or disembark a bus (even if it has a lift/ramp)

___Condition id temporary: expected to last until: _____

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___ Other (please explain):

_____

_____

Is the condition permanent? ___ Yes ___ No ___ Unknown

Does the applicant require a Personal Care Attendant (PCA)? ___ Yes ___ No ___ Sometimes

Provider Certification

By Signing this below, I certify that the above information is accurate and provided with the applicant's consent.

Provider Name (Print): _____

Medical License Number: _____

Title/ Profession: _____

Signature: _____

Date: _____

Return Completed Form To:

City of Joplin Public Transportation Department

123 S Main St

Joplin, MO 64801

Or Fax to 417-625-4747