



ADA APPLICATION OVERVIEW AND INSTRUCTIONS

The Americans with Disabilities Act (ADA) requires that ADA Paratransit Service be provided as an alternative mode of transportation for qualified persons who are unable to use Valley Metro bus or light rail services due to a disability. ADA regulations state that individuals must apply for ADA Paratransit Service and be determined ADA eligible in order to be provided ADA Paratransit Service.

Following is a Valley Metro application for ADA Paratransit Service. When you have completed the application, call the Valley Metro Mobility Center at 602.716.2100, option 2 to schedule your appointment.

On the day of your appointment, please bring the following:

- **Completed application** - Please answer all questions, sign and date
- **A list of your current medications** (if any)
- **Supporting documentation regarding your disability** (if any)
- **Proof of identity** - State ID, Driver's license, Birth certificate, etc.
- **Equipment** - Any necessary equipment that you use in normal travel or would need to use when traveling on transit services
- **Power wheelchair and scooter users** - Please make sure that your battery is fully charged

Please be advised that you could be asked to travel up to 3/4 of a mile during your evaluation and you should wear comfortable clothing and shoes. Be advised that you could be away from home for up to two hours. Please bring a small snack or drink, medications, sufficient oxygen, etc. should you need them while you are away. You may bring someone with you if you need assistance. It is important to bring someone with you if you require assistance in translating English to another language. Please avoid bringing children or additional person(s) who are not needed to assist you.

Valley Metro will complete the determination process within 21 days of your in-person assessment. If that does not happen, you will receive presumptive eligibility and will be allowed to use ADA Dial-a-Ride until the process is complete.

If you have any questions prior to your evaluation, feel free to call our office at 602.716.2100.

Sincerely,

Valley Metro Mobility Center
4600 E. Washington St., Suite 102
Phoenix, AZ 85034



VALLEY METRO ADA PARATRANSIT APPLICATION

PERSONAL INFORMATION - Print clearly

Last name _____ First _____ Middle _____

Female _____ Male _____ Date of birth _____

HOME ADDRESS

Street _____ City _____ State AZ Zip _____

Day phone _____ Evening phone _____

TDD Yes _____ No _____

MAILING ADDRESS (If different from above)

Street _____ City _____ State AZ Zip _____

EMERGENCY CONTACT

Name _____

Day phone _____ Relationship _____

Do you require information in an alternate format? Yes _____ No _____

If yes, please indicate: Braille _____ Large print _____ Other _____

Your primary language: English _____ Spanish _____ Other _____

MOBILITY INFORMATION - Print clearly

What is your disability/medical condition/diagnosis? _____

Which of the following mobility aids or equipment do you use?

- | | | | | |
|---------|----------------|-------------------|-------------|------------------|
| Cane | Crutches | Manual wheelchair | Oxygen tank | Power wheelchair |
| Scooter | Service animal | Walker | White cane | |

List your current medications:

Signature _____ Date _____

Please call 602.716.2100, option 2 to schedule an appointment. You must bring a valid photo identification and this completed ADA paratransit service application to your in-person assessment appointment.

DO NOT MAIL

Valley Metro may need to contact your rehabilitation professionals or healthcare providers for additional information on how your disability prevents you from using bus or light rail service. Please list licensed or certified rehabilitation or health professionals who can provide information about your abilities. All information will be confidential and only utilized to determine eligibility for ADA Paratransit Service.

MEDICAL CONTACT INFORMATION - Print clearly

Physician or other professional _____

Name of office _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip _____

Physician or other professional _____

Name of office _____

Phone # _____ Fax # _____

Address _____

City _____ State _____ Zip _____

CERTIFICATION AND AUTHORIZATION

I certify that the information provided in the application is true and correct. I understand that falsification of information may result in denial of service. I authorize the professionals listed above to release to Valley Metro information about my disability and its effect on my ability to travel on the bus or light rail service. Unless earlier revoked, this form permits the professional listed to release information up to 90 days from the date below.

Signature _____ Date _____

Print name _____

Signature of person assisting applicant (if any) _____

I choose not to provide contact information for a professional familiar with my disability.

Signature _____ Date _____

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