



*Suburban Mobility Authority for Regional Transportation*

## **Americans With Disabilities Act (ADA) Eligibility Package**

Attached are forms necessary to determine eligibility for **SMART's ADA Paratransit (Parallel Transportation) Service** within Wayne, Oakland and Macomb counties. **ADA Paratransit Service** is an advanced reservation, curb-to-curb service that is provided for persons who are unable to use **SMART's** fixed route bus service because of a disability.

### **WHO IS ELIGIBLE?**

- A person with a disability who cannot get on, off or ride an accessible fixed route bus because of their disability is unconditionally eligible. For example, persons with developmental or cognitive impairments often qualify under this category.
- A person whose disability **prevents** them from getting to a fixed route bus stop, but is still able to ride a bus, may be conditionally eligible. For example, if construction, lack of a sidewalk or snow prevents access, the rider is eligible for ADA service until conditions improve.

### **ADA PARATRANSIT SERVICE**

Service areas, hours of operation and transfer requirements are comparable to **SMART's** fixed route bus service. The **ADA Paratransit** one-way fare is **\$3.00**, including transfers.

The **SMART ADA Paratransit** service area includes any address that measures 3/4 of a mile or less from a **SMART** regular fixed route bus stop.

### **HOW TO APPLY**

1. It's easy to apply! This **Application for ADA Paratransit Certification** must be filled out and signed by you or an authorized individual. On the release of information page, you indicate who has or will fill out your professional verification. You sign the release so **SMART** may contact the professional if we need clarification of any information in the application. The **Request for Professional Verification** page may only be completed and signed by a state licensed medical professional, rehabilitation specialist, or social worker who has documentation of your disability. Under the **Health Information Privacy Act**, your medical information remains confidential.
2. Return the completed forms to:

**SMART** • Attention: ADA Office

Buhl Building • 535 Griswold Street, Suite 600 • Detroit, MI 48226

Questions? Call **(313) 223-2100** and ask for the **ADA Coordinator**.

# 2009 Application for ADA Paratransit Certification

The information obtained in this application will be used by the Suburban Mobility Authority for Regional Transportation (**SMART**) to determine eligibility for **ADA Paratransit Service**. This information may be shared with **Detroit MetroLift** and other transit providers to help schedule trips within their service area and verify eligibility.

It is important that you answer every question on this application. Evaluation of your request cannot begin until the form is completed and received at the SMART offices, together with the signed professional verification form. Once all of the forms have been received, a determination is made within 21 days. You will receive notification of this determination by US mail.

**UNREADABLE OR INCOMPLETE APPLICATIONS WILL BE RETURNED.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

MALE  FEMALE

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1. What is the nature of your disability? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is this disability temporary?

YES  NO

If YES, expected duration until \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Do you travel with a personal care attendant?

ALWAYS  SOMETIMES  NEVER

4. Please explain how this disability prevents you from getting to a fixed route bus stop, waiting at a fixed route bus stop or riding a regularly scheduled fixed route bus?

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5. Are there any other effects of your disability that we should know about? \_\_\_\_\_

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6. Please check the mobility aid(s) that you will most often use when riding the ADA bus.

- |   |  |                                     |                                     |
|---|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> MANUAL WHEELCHAIR    | <input type="checkbox"/> POWERED SCOOTER | <input type="checkbox"/> WALKER     | <input type="checkbox"/> ORTHO CANE |
| <input type="checkbox"/> LARGE WHEELCHAIR     | <input type="checkbox"/> LARGE SCOOTER   | <input type="checkbox"/> CRUTCHES   | <input type="checkbox"/> WHITE CANE |
| <input type="checkbox"/> MOTORIZED WHEELCHAIR | <input type="checkbox"/> SERVICE ANIMAL  | <input type="checkbox"/> LEG BRACES | <input type="checkbox"/> NONE       |

7. How far are you able to walk or wheel?

Walking \_\_\_\_\_ block(s) or \_\_\_\_\_ feet      If using my wheelchair \_\_\_\_\_ block(s) or \_\_\_\_\_ feet

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If this application has been completed by someone other than the person requesting certification, that person must complete the following:

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Suburban Mobility Authority for Regional Transportation**

## **2009 Release of Information**

In order to allow **SMART** to evaluate your request, it may be necessary to contact a physician or other professional to discuss the information you have provided. Please complete the following:

The following licensed medical professional/social worker/rehabilitation specialist may document, and is familiar with, my disability. I authorize him/her to provide information to **SMART** in order to complete the **ADA Paratransit Certification Process**.

**Name of professional:** \_\_\_\_\_

**Title/Position:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

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I hereby certify that the information given above and in this application is correct.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please return this application to:  
**SMART • Attention: ADA Office**  
**Buhl Building**  
**535 Griswold Street, Suite 600**  
**Detroit, MI 48226**



**Suburban Mobility Authority for Regional Transportation**

## Request for Professional Verification

**(This page may not be completed by the applicant.)**

Federal law requires that **SMART** provide parallel transit services to persons who cannot use available fixed route bus service. The information provided will allow **SMART** to make an appropriate evaluation of this request and its application to specific trip requests. Please fill in all sections that pertain to the applicant's disabilities as they relate to using public transportation. Thank you for your cooperation in this matter. **Unreadable or incomplete applications will be returned.**

Name & date of birth of applicant \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

1. What is your professional relationship to the applicant?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> PHYSICIAN           | <input type="checkbox"/> PT / OT       | <input type="checkbox"/> MOBILITY SPECIALIST       |
| <input type="checkbox"/> PHYSICIAN ASSISTANT | <input type="checkbox"/> SOCIAL WORKER | <input type="checkbox"/> REHABILITATION SPECIALIST |
| <input type="checkbox"/> NURSE/PRACTITIONER  | <input type="checkbox"/> COUNSELOR     | <input type="checkbox"/> OTHER                     |

2. What is/are the applicant's disabilities? \_\_\_\_\_  
\_\_\_\_\_

3. Is this disability temporary?

YES  NO If YES, expected duration until \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

4. Please check the mobility aids that the applicant uses.

- |   |  |                                     |                                     |
|---|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> MANUAL WHEELCHAIR    | <input type="checkbox"/> POWERED SCOOTER | <input type="checkbox"/> WALKER     | <input type="checkbox"/> ORTHO CANE |
| <input type="checkbox"/> LARGE WHEELCHAIR     | <input type="checkbox"/> LARGE SCOOTER   | <input type="checkbox"/> CRUTCHES   | <input type="checkbox"/> WHITE CANE |
| <input type="checkbox"/> MOTORIZED WHEELCHAIR | <input type="checkbox"/> SERVICE ANIMAL  | <input type="checkbox"/> LEG BRACES | <input type="checkbox"/> NONE       |

5. How far is the applicant able to walk or wheel?

Walking \_\_\_\_\_ block(s) or \_\_\_\_\_ feet If they use a wheelchair \_\_\_\_\_ block(s) or \_\_\_\_\_ feet

6. Please indicate the applicants level of independence (CHECK ONLY ONE).

- IS ABLE TO GET TO A BUS STOP AS LONG AS THERE IS A SIDEWALK
- CAN INDEPENDENTLY GET TO THE STREET FOR CURB-TO-CURB SERVICE
- CAN GET TO THE STREET ONLY WITH THE HELP OF A PERSONAL CARE ATTENDANT
- TOTALLY DEPENDENT. DRIVER MUST ESCORT PASSENGER DOOR-TO-DOOR

7. Is the applicant legally blind? Acuity? \_\_\_\_\_ / \_\_\_\_\_    \_\_\_\_\_ / \_\_\_\_\_     YES     NO
8. Does the applicant have a cognitive disability?     YES     NO
9. Is the applicant sensitive to heat, cold, the sun, etc.?     YES     NO
- If yes, please explain: \_\_\_\_\_

10. Is the applicant able to:
- Give address and telephone numbers upon request?     YES     NO     SOMETIMES
- Recognize a destination or landmark?     YES     NO     SOMETIMES
- Deal with unexpected change in routine?     YES     NO     SOMETIMES
- Ask for, understand and follow directions?     YES     NO     SOMETIMES

11. Please explain any **SOMETIMES** responses from question #10 above or describe any other effects of the disability not already provided elsewhere on this form.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Your Name:** \_\_\_\_\_

**Title/Position:** \_\_\_\_\_

**Permanent Michigan Professional License / ID#:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

\_\_\_\_\_

**Office Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Signature of Professional:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Return this form along with the **Application for ADA Paratransit Certification** to:

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