2000 S May Avenue
Oklahoma City, OK 73108
telephone 405.235.RIDE
fax 405.316.2891
www.gometro.org

Application #
Punch Card #

REQUEST FOR CERTIFICATION OF ELIGIBILITY

To Applicant:

The information obtained from this application will be used by METRO Transit to help provide you with transportation services. If you have any questions regarding this application or our services, please call 297-2891.

Applications will not be considered complete until all requested information is received.

1. Name **Last** ______________________ **First** ______________________ **Initial** ________

2. Street Address ____

   Nearest Major Intersection ____________________ / ____________________

3. City ______________________ State ______________________ Zip ________

4. Telephone Number (Home) ______________________ (Work) ______________________

5. Date of Birth _____ / _____ / _____ Age______ Social Security Number _______ / _______ / ________
   Month **Day** **Year**

6. How did you learn about our services? ____________________________________

7. Which of the METRO Transit Special Transportation Services are you applying for?
   See METRO Transit brochure: **Special Services Transportation.**

METRO Lift ☐ **Share-A-Fare Discount Taxi** ☐ **Half Price Bus** ☐

Senior Citizen Grocery Shopping Shuttle ☐

NOTE: If you are applying for Half Price Bus and you have a Medicare card, please provide a copy of your Medicare card. If you are applying only for Half Price Bus and you have provided a copy of your Medicare card, it is not necessary to answer the remaining questions on this form.

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If you are applying based on a disability, please complete the following questions:

8. Do you use our regularly scheduled bus service? ____

9. What is your disability? ____

10. If you are not to use our regularly scheduled bus service due to a disability, describe how your disability prevents you from using the bus system. **(Use the back of this sheet if necessary.)**

____

____

Is this condition temporary? **Yes** ☐ **No** ☐ If yes, on what date will you be able to use our regular bus service again? **Date______/___________/___________**

11. What is your form of communication? **(Please check all that apply.)**

Verbal ☐ Written ☐ Sign Language ☐

12. Do you use any of the following aides to get around? **(Check all that apply)**

Manual Wheelchair ☐ **Electric Wheelchair** ☐ **Powered Scooter** ☐ **Cane** ☐

Crutches ☐ **Walker** ☐ **Guide Dog** ☐ **Personal Care Attendant (PCA)** ☐

13. Operational policy states that when using “METRO-Lift” service, **you must be waiting at the curb** when the lift-equipped van arrives to pick you up. If you cannot manage this on your own, “METRO-Lift” allows a PCA to assist you and accompany you on your trip. Will a PCA be assisting or accompanying you when you are using METRO-Lift? **Yes** ☐ **No** ☐

14. Is your place of residence equipped with a ramp? **Yes** ☐ **No** ☐

15. How often do you plan to use this service? **(Please fill in the blanks)**
times per week___________ **times per month__________**

16. Please answer the following questions:

Can you walk 200 feet without the help of another person?
Yes ☐ **No** ☐ **Sometimes** ☐ **(Explain)____**

Can you walk ¼ mile without the help of another person?
Yes ☐ **No** ☐ **Sometimes** ☐ **(Explain)____**

Can you ride great distances on a bus by yourself?
Yes ☐ **No** ☐ **Sometimes** ☐ **(Explain)____**

Can you climb three 12-inch steps without the help of another person?
Yes ☐ **No** ☐ **Sometimes** ☐ **(Explain)____**

Can you wait outside alone for 10 minutes?
Yes ☐ **No** ☐ **Sometimes** ☐ **(Explain)____**

17. If, up to this point, this application has been filled out by a relative, staff person, or someone other than the ADA applicant, that person should complete the following:

Name______________________________________Relationship to Applicant______________________
Name of Organization____
Address____City________State________Zip_________
Daytime Phone_____________________________________FAX #________________________________
Signature____Date_____/_____/________

18. In case of emergency, who should be contacted?
Name______________________________________Relationship to Applicant______________________
Address____________________________________City_______________State________Zip_________
Daytime Phone______________________________Home Phone________________________________

19. I hereby certify that the information given above is correct. I agree to notify the METRO Transit Special Services at 297-2891 of any changes in my status, which may affect my eligibility to use the service. I understand and agree to hold **COPTA** and the **City Of Oklahoma City** harmless against all Claims or liability for damages to any person, property, or personal injury occurring as a result of my failure to equip or maintain the safety measures of the adaptive equipment or certified guide/service animal that I require for mobility. I have read and fully understand the conditions for service outlined above and agree to abide by them.

Applicant's Signature____ Date______/______/______

20. If you are applying for services based on a disability, **METRO Transit** may contact your doctor to obtain information about your disability. A "Medical Information Form" will be mailed or faxed to your Doctor. It will speed up the application process if you call and request your Doctor to complete the **"Medical Information Form"** and return it to **METRO Transit** as quickly as possible.

If you are applying for services based on a disability, please complete the attached Release of Information.

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If you are applying based on a disability, please complete this page and return to METRO Transit.
METRO TRANSIT will contact your doctor.

RELEASE OF INFORMATION

Last:	**First:**	**Middle:**
Other Names Used:	**Date of Birth / /**	**SS#**
Address:	**City State**	**Zip**
Home Phone: ( )	**Work Phone: ( )**	

I hereby request release of protected health information for the purpose of completing the METRO Transit "Medical Information Form". I further request my physician to complete the following: "METRO Transit Medical Information Form". PLEASE DO NOT SEND MEDICAL RECORDS

Mail or fax the "Medical Information Form" to:

Information From:			**Information To:**
Doctor Name:			**METRO Transit**
Address:			**2000 S May Avenue**
City	**State**	**Zip**	**Oklahoma City, OK 73108**
Phone:	**FAX**		**PHONE 297-2891 FAX 316-2891**

METRO Transit does not pay for copies of medical records.

I understand:

- **I may revoke this authorization at any time, in writing. My revocation will not apply to information already obtained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be one (1) year from the date of signature.**
- **Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.**
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**
- **The information authorized for release also may include protected health information related to mental health.**
- **The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentially rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.**

_______________________________________ Signature of Patient, Parent or Legally Authorized Representative

_______________ Relationship to Patient

__________ Date

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