Metro Paratransit
In-Person Assessment Form: Bring completed form to your assessment.

Medicaid Number:_____

Title (circle one): Mr. Ms. Dr.

Last Name _____ First Name_____ M.I._____
Current Address_____ Apt. #:_____
City: _____ State: _____ Zip Code: _____
Name of Residence (if appropriate):_____
Phone Numbers/Home: _____ Cell: _____
Date of Birth: _____ Age: _____ Sex: [ ] M [ ] F

***Bring current ID and/employer or school bus pass.**

Mailing Address: where any written information/notification concerning Metro Paratransit should be sent (only **one** address for mailing purposes please):
[ ] Same as applicant Address, **or**

Address:_____
City: _____ State: _____ Zip Code: _____
Contact Person's Name (if applicable):_____
Phone: _____ Agency: _____

In case of an emergency, list the names of two people, physicians, family, agencies or others familiar with your disability, that Metro can contact:

Name:_____Work/Cell#_____Home#_____
Address:_____
City:_____ State:_____ Zip code:_____
Relationship_____

Name:_____Work/Cell#_____Home#_____
Address:_____
City:_____ State:_____ Zip code:_____
Relationship_____

What is your disability/ diagnosis?

Do you use a wheelchair or scooter : How wide is it? _____ inches.
How long is it? _____ inches. How heavy is it **when occupied** (total weight)? _____ pounds
*****This information is not used to determine paratransit eligibility. It is the applicant's responsibility to know the dimensions of their mobility device and whether it exceeds the minimum standards specified in the ADA.

***METRO must be able to verify your stated disability. Please include support documents relating to your disability and be prepared to explain the reasons you are able and unable to use METRO's fixed route bus service. If you have a medically defined heat/ cold sensitivity, please provide medical documentation of the range of temperatures you can tolerate.**

To verify your disability, please list the names of two professionals, which may include physicians, agencies or others familiar with your disability, if verification of information is required:

Name:_____ Telephone #:_____
Address:_____Title:_____
City:_____ State:_____ Zip Code:_____

Name:_____ Telephone #:_____
Address: _____Title:_____
City:_____ State:_____ Zip Code:_____

Release of Information

I, the applicant, understand that the purpose of this application form is to determine my eligibility to use Metro Paratransit Service. I agree to release the information requested to Metro and any eligibility review panel, and understand that the information contained herein will be treated confidentially. I understand further the Metro reserves the right to request additional information at its discretion. I also allow Metro Paratransit Service to refer and exchange applicant information with the Dane County Travel Training Program. **Original** signature required. Copies or facsimiles of signatures will **not** be accepted (please do **not** fax or email this form).

Signature of Applicant_____Date_____

Printed Name of Applicant_____

Printed Name of Preparer_____

If preparer represents an agency, please print the agency name here:
_____Phone #_____

Signature of Parent or Legal Guardian _____Date_____

Printed Name of Parent or Legal Guardian_____

I _____ (print name) completed this application and am responsible for its truth and accuracy. Thank you for completing this application form.

Please Bring Completed Form and Documents to Your In-Person Assessment