Metro Transit
1245 East Washington Avenue, Suite 201
Madison, Wisconsin 53703
Customer Service: (608) 266-4466

Paratransit In-Person Assessment Application

Title (please check one): ☐ Mr. ☐ Ms. ☐ Dr.

Last Name _____ First Name_____ M.I._____

Current Address_____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Name of Residence/building complex: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F

Please Bring completed form to your assessment, along with current photo ID and your employer or school bus pass, if applicable.

MAILING ADDRESS:
Where any written information/notification concerning Metro Paratransit should be sent (only **one** address for mailing purposes please):

☐ **SAME AS APPLICANT ADDRESS ABOVE; OR MATERIALS SHOULD BE MAILED TO:**

Address: _____

City: _____ State: _____ Zip Code: _____

C/O Person's Name: _____

Phone: _____ Agency: _____

IN CASE OF AN EMERGENCY:
List (2) people (family members, physicians, agencies or others), who are familiar with your disability.

Name:_____Work/Cell#_____Home#_____

Address:_____

City:_____ State:_____ Zip code:_____

Relationship_____

Name:_____Work/Cell#_____Home#_____

Address:_____

City:_____ State:_____ Zip code:_____

Relationship_____

PLEASE LIST SPECIFIC DISABILITIES/DIAGNOSIS(S):

_____

_____

_____

CHECK MOBILITY DEVICES YOU CURRENTLY USE: Please check all that apply

☐ Power wheelchair → ☐ Standard OR ☐ Oversized	☐ Non-folding walker
☐ Manual wheelchair → ☐ Standard OR ☐ Oversized	☐ Service animal
☐ Scooter	☐ Cane
☐ Fold-up walker	☐ White cane

METRO must be able to verify your stated disability. If you already have support documents relating to your disability that you would like to submit, please bring them with you (this is optional). **Be prepared to explain why you are able and/or unable to use METRO's accessible fixed route bus service.**

Please list the names & contact information of **two different** professionals who can verify your disability (examples: physician, social worker, case manager, therapist, chiropractor, psychologist, psychiatrist).

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 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. **AN ORIGINAL SIGNATURE IS REQUIRED ON THIS APPLICATION. NOTE:** Copies or facsimiles will **NOT** be accepted (please do **not** fax or email this form).

Signature of Applicant_____Date_____

Printed Name of Applicant_____

Signature of Parent/Legal Guardian (If client has one) _____Date_____

Printed Name of Parent or Legal Guardian_____

PRINTED NAME OF APPLICATION PREPARER_____

If preparer represents an agency, list agency name: _____ Phone #_____

PLEASE BRING THE COMPLETED FORM AND DOCUMENTS TO YOUR IN-PERSON ASSESSMENT