



ADA PARATRANSIT SERVICE APPLICATION FORM

(Revised 3/2026)

Attached is the application for Green Bay Paratransit Service. Please review it carefully, reading the description of disability as it pertains to the Americans with Disabilities Act of 1990.

This application and professional verification will be reviewed and eligibility will be determined. It is extremely important that both forms are filled out completely. Any incomplete applications will be returned. Within twenty-one (21) days of receipt of a completed application, an eligibility determination will be made. The submission of this application does not guarantee eligibility. Eligibility determination will be in writing and will inform the applicant of the acceptance or denial of eligibility, and in the case of denial, the reason(s) for such. In the event that eligibility is denied, a description of our appeal process will be included with the written determination.

ADA Paratransit Eligibility Standards:

- Any individual with a disability who is unable, as a result of a physical or mental impairment (including vision impairment), and without the assistance of another individual (except the operator of a wheelchair lift or other boarding assistance device), to board, ride, or disembark from any vehicle on the system which is readily accessible to and usable by individuals with disabilities.
- Any individual with a disability who needs assistance of a wheelchair lift or other boarding assistance device and is able, with such assistance, to board, ride and disembark from any vehicle which is readily accessible to and usable by individuals with disabilities if the individual wants to travel on a route on the system during the hours of operation of the system at a time, or within a reasonable period of such time, when such a vehicle is not being used to provide designated public transportation on the route.
- Any individual with a disability who has a specific impairment-related condition which prevents such individual from traveling to a boarding location or from a disembarking location on such system.

After reviewing the above information, if you feel that your disability may fit into one of the above categories, please complete the Request for Certification of ADA Eligibility Form attached. If you do not meet the criteria defined herein, please contact Green Bay Metro at 448-3450.

Please Type or Print Clearly. Incomplete Applications Will Be Returned.

Applicant Information: _____

Medicaid Number: _____

(Otherwise known as Medicaid, Title XIX or MA-not to be confused with Medicare)

Last Name: _____ First Name: _____ M.I.: _____

Current Address _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Name of Residence (if applicable): _____

Phone Numbers/Home: _____ Cell: _____

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

Primary Language: ☐ English ☐ Spanish ☐ Sign ☐ Other: _____

Are you member of any of the following social service agencies?

☐ Community Care ☐ IRIS ☐ MTM ☐ Brown County Human Service

☐ Care Wisconsin ☐ Lakeland ☐ Other: _____

Mailing Address: where any written information/notification concerning Green Bay Metro Paratransit should be sent (only **one** address for mailing purposes please):

☐ Same as applicant Address, **or** ☐ **Use only the address below for mailing:**

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Person's Name (if not the client): _____

Phone: _____ Agency: _____

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

Name: _____ Work#: _____ Home#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____

Name: _____ Work#: _____ Home#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____

1. Are you able to use Green Bay Metro Fixed Route accessible buses for any of your transportation needs? ☐ Yes ☐ No ☐ Sometimes (Explain) _____

2. What is the disability that prevents you from using Green Bay Metro fixed route services?

3. Are the conditions you described:
☐ Permanent ☐ Vary day-to-day or ☐ Temporary?

If temporary, how long do you expect this to continue? _____

4. If provided with the appropriate training and practice, would you be able to use Green Bay Metro fixed route bus service? ☐ Yes ☐ No ☐ Sometimes (Explain)

5. How does this disability prevent you from using fixed route services? (Explain completely. If necessary, continue on separate sheet.)

6. Are there any other effects of your disability or other medical conditions of which Green Bay Metro needs to be aware? (If necessary, continue on separate sheet.)

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS USED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCUARATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY GREEN BAY METRO.

7. Which, if any, of the following aids to mobility do you use? (Check all that apply.)

- | | | |
|--|--|--|
| ☐ Cane | ☐ Service Animal | ☐ Communication Board |
| ☐ White Cane | ☐ Power Wheelchair | ☐ Large Power Chair (Exceeds ADA) |
| ☐ Walker | ☐ Power Scooter (3-Wheeler) | ☐ Oxygen Tank |
| ☐ Crutches | ☐ Manual Wheelchair | ☐ Other Aid: _____ |
| ☐ Augmentative Communication Device | ☐ NONE | |

8a. If you use an oversize wheelchair or scooter, what is the:

Length _____ inches Width _____ inches

8b. Does the total weight of your wheelchair or scooter and yourself exceed 800 pounds?

☐ Yes ☐ No

9. Will an attendant need to travel with you at any time?

☐ Yes ☐ No ☐ Sometimes (Explain) _____

10. When traveling, will you be able to sign your name on a trip receipt?

☐ Yes ☐ No ☐ Sometimes (Explain) _____

Please answer the following questions:

11a. Can you travel a ½ block without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

11b. Can you travel ¼ mile (3 blocks) without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

11c. Can you travel ¾ mile (9 blocks) without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

12. Can you climb 12-inch steps without assistance?

☐ Yes ☐ No ☐ Sometimes (explain) _____

If yes, how many in succession? _____

13. Can you wait outside without support for 10 minutes?

☐ Yes ☐ No ☐ Sometimes (explain) _____

14. I hereby certify that the information given above is correct.

Signed _____ Date _____

15. If someone else other than the applicant completed this form on behalf of the applicant, that person must complete the following:

Name _____ Date _____

Daytime Phone _____

Agency affiliation/Relationship to Applicant _____

Address _____

Information about ADA eligibility /certification: 920-448-3450

Please return it to:

**Green Bay Metro Paratransit, 901 University Avenue, Green Bay, WI 54302
or Fax 920-448-3461**

For Metro Office Use Only

Client Id# _____ Date Action Needed: _____

Date Application Received: _____ ☐ Approved ☐ Denied Date: _____

Eligibility Category ☐ 1 ☐ 2 ☐ 3 ☐ Winter Only ☐ 2/3 – Winter/Summer _____

☐ Conditional Eligibility: _____

☐ Temporary Expires: _____ Approved By Whom: _____

General Comments: _____

Extenuating Conditions: _____

Status: ☐ New ☐ Temporary ☐ Recertification ☐ Extension ☐ Evaluation

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As part of your paratransit eligibility determination, Green Bay Metro may contact your current doctor for information on your medical condition and your functional abilities. Please list the doctor or licensed healthcare professional most familiar with your condition. All information received will be kept confidential and only utilized by Green Bay Metro staff to determine your eligibility for ADA Paratransit Services. Refusal to provide this release will prevent Green Bay Metro from completing your eligibility determination and will result in a denial of your application.

GREEN BAY METRO DOES NOT PAY FOR MEDICAL INFORMATION OR FORM COMPLETION FEES

Please print and complete all blanks

Patient First & Last Name: _____

☐ Physician ☐ Ophthalmologist ☐ Other _____

Physician Name: _____

Name of Office/Practice Group: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Privacy Regulation.

CERTIFICATION AND AUTHORIZATION

I understand that falsification of information may result in denial of Green Bay Metro paratransit service. I authorize the licensed health professional listed above to release to Green Bay Metro information about my disability and its effect on my functional ability to travel on the fixed route bus. Unless earlier revoked in writing, this form permits the professional listed to release information to Green Bay Metro up to one year from the date below.

Applicant Signature: _____ Date _____

Print Name: _____

REQUEST FOR PROFESSIONAL VERIFICATION

This form must be completed by a **licensed medical professional**

The attached authorization form has been submitted by _____, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law requires that Green Bay Metro provide paratransit services to persons who cannot utilize available accessible fixed route (bus) services. Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location, or riding on a fixed route system more difficult or less comfortable, are **not** reasons for paratransit eligibility. The information you provide will allow us to make an appropriate evaluation of the request and its application to specific trip requests. Thank you for your cooperation in this matter.

Capacity in which you know the applicant: _____

Medical Diagnosis of condition causing disability: _____

Is the condition temporary? ☐ No ☐ Yes ☐ Expected duration until _____

How does this condition affect the individual's ability to use accessible Green Bay Metro fixed route (bus) services? _____

If provided with appropriate training and practice, would this person be able to use Green Bay Metro fixed route (bus) service?

☐ Yes ☐ No ☐ Sometimes (explain) _____

If the person has a disability affecting mobility, is the person able to:

Travel 200 feet without assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Travel one half block without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Travel ¼ mile without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Travel ¾ mile without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Climb 12-inch steps without assistance?

☐ Yes ☐ No ☐ Sometimes (explain) _____

If yes, how many in succession? _____

Wait outside without support for 10 minutes?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Does this person use any mobility aids? If so, what? _____

Is this person able to negotiate ice/snow during travel?

☐ Yes ☐ No ☐ Sometimes (explain) _____

Is this person able to travel in extreme hot/cold weather?

☐ Yes ☐ No ☐ Sometimes (explain) _____

If the person has a visual impairment:

Visual acuity with best correction: Right eye _____ Left eye _____ Both eyes _____

Visual fields: Right eye _____ Left eye _____ Both eyes _____

If the person has a cognitive disability:

Is the person able to do the following?

Give address and telephone numbers upon request?

☐ Yes ☐ No

☐ Yes ☐ No

Deal with unexpected situations or changes in routine?

☐ Yes ☐ No

Ask for, understand, and follow directions?

☐ Yes ☐ No

Safely and effectively travel through crowded and/or complex facilities?

☐ Yes ☐ No

Is there any other effect of the disability of which Green Bay Metro should be aware? If so, please describe. (If necessary, continue on separate sheet.) _____

Your Name _____

Office Address _____

Office Telephone Number _____

Wisconsin Medical License Number _____

Signature _____ Date _____

This application must be fully completed. For information about ADA eligibility and the certification process, contact Green Bay Metro at 448-3450.

Return completed applications to:

☐ **Metro's Paratransit Service**

Send to:
901 University Ave.
Green Bay, WI 54302
FAX: 920-448-3461

☐ **Curative Connections Service**

Send to:
2900 Curry Ln.
Green Bay, WI 54311

☐ **Both Services** *Documents will be shared with both agencies

Send to:
901 University Ave.
Green Bay, WI 54302
FAX: 920-448-3461