



ADA PARATRANSIT SERVICE APPLICATION FORM

(Revised 9/2017)

Attached is the application for Green Bay Metro's Paratransit Service. In an effort to simplify the process, we have partnered with Curative Connections Transportation Service. You are able to complete one application to apply for both services. Please review it carefully, reading the description of disability as it pertains to the American with Disabilities Act of 1990.

This application and professional verification will be reviewed and eligibility will be determined. It is extremely important that all 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 the 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 the 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.

Questions about Green Bay Metro's Paratransit Service: 920-448-3452.



Curative Connections Eligibility Standards:

- If the applicant is over the age of 60, no application is needed for Curative Connections Service, regardless of having or not having a disability. Simply call 227-4272 to get registered.
- If applicant is under the age of 60, this application is needed. Eligibility is determined on a case-by-case basis.

This application and professional verification will be reviewed and eligibility will be determined. It is extremely important that all 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 the appeal process will be included with the written determination.

Questions about Curative Connections Service: 920-227-4272.

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

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 appropriate): _____

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?

IRIS Community Care MTM Brown County Human Service

Care Wisconsin Lakeland AFCSP Funding Other:

Mailing Address: where any written information/notification concerning Green Bay Metro Paratransit and/or Curative Connections Service 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 Green Bay Metro and/or Curative Connections 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? How does this disability prevent you from using fixed route services? (Explain completely. If necessary, continue on separate sheet.)

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. Are there any other effects of your disability or other medical conditions of which Green Bay Metro and/or Curative Connections 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 ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE.

6. Which, if any, of the following aids to mobility do you use? (Check all that apply.)
- | | | |
|--|--|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Communication Board |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Large Power Chair (Exceeds ADA) |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Power Scooter (3-Wheeler) | <input type="checkbox"/> Oxygen Tank |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Other Aid: _____ |
| <input type="checkbox"/> Augmentative Communication Device | <input type="checkbox"/> NONE | |

7. Does the total weight of your wheelchair or scooter and yourself exceed 800 pounds?
 Yes No

8. Will an attendant need to travel with you at any time?
 Yes No Sometimes (Explain) _____

9. When traveling, will you be able to sign your name on a trip receipt?
 Yes No Sometimes (Explain) _____

10. Please answer the following questions:
 Can you travel a 1/2 block without the assistance of another person?
 Yes No Sometimes (explain) _____
 Can you travel 1/4 mile (3 blocks) without the assistance of another person?
 Yes No Sometimes (explain) _____
 Can you travel 3/4 mile (9 blocks) without the assistance of another person?
 Yes No Sometimes (explain) _____

11. Can you climb 12-inch steps without assistance?
 Yes No Sometimes (explain) _____
 If yes, how many in succession? _____

12. Can you wait outside without support for 10 minutes?
 Yes No Sometimes (explain) _____

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

Signed _____ Date _____

14. I understand that I may be eligible for other transportation services through Curative Connection. I hereby authorize Green Bay Metro to share my complete application, including Request for Professional Verification with Curative Connection for the purposes of determining my eligibility.

Signed _____ Date _____

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

Name _____ Daytime Phone _____

Agency affiliation/Relationship to Applicant _____
Address _____

[] Check here if all Program correspondence should be sent to the applicant in care of this address.

Signature _____ Date _____

I am applying for:

- Green Bay Metro's Paratransit Service**
Send to:
901 University Ave.
Green Bay, WI 54302
- Curative Connections Service**
Send to:
2900 Curry Ln.
Green Bay, WI 54311

- Both Services**
Send to:
901 University Ave.
Green Bay, WI 54302
*Documents will be shared with both agencies

For 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 [] Extention [] Evaluation

REQUEST FOR PROFESSIONAL VERIFICATION

This form must be completed by a licensed medical professional

Dear

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 effecting 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 448-3452. This form may be shared between Metro's paratransit service and Curative Connections.

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

MEDICAL INFORMATION RELEASE OF AUTHORIZATION

Include this form with your application.

In order for Green Bay Metro and/or Curative Connections to evaluate your request, it may be necessary to contact a medical professional to confirm the information that you have provided. Please complete the following information and authorization form.

The following health care professional is familiar with my disability and is authorized to provide Green Bay Metro and/or Curative Connections all information required to complete this certification.

Occupational Therapist Ophthalmologist Physician
 Physical Therapist Registered Nurse Other _____

Professional's Name _____

Address _____

City _____ State _____ Zip _____ Telephone Number _____

Your Name (Print) _____

Signature _____

The client named above has requested Green Bay Metro subsidized paratransit service and/or Curative Connections service. Green Bay Metro paratransit service provides transportation to individuals with disabilities who are unable to use the Green Bay Metro fixed route (bus) system.

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- 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 the 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.