



ADA Eligibility Application

Please read the introductory information in the official *LinkAssist Service Guide* and answer all questions as thoroughly and accurately as possible.

PERSONAL INFORMATION

PLEASE PRINT

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

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female ☐ N/A

Format (Ex: Braille, Large Format, Audio) : _____

Email Address: _____

Street Address: _____ Apt.# _____

Building Complex or Name: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

TDD: _____

EMERGENCY CONTACT**OPTIONAL**

First Name: _____ Last Name: _____

Email Address: _____ Phone Number: _____

Relationship: _____

PERSONAL CARE ATTENDANT

A Personal Care Attendant (PCA) is someone you require to travel with you to complete your trip. PCAs are not provided and must be arranged by the rider. They may ride at no cost.

Do you need a personal care attendant? ☐ Yes ☐ No**APPLICATION ASSISTANCE**Did someone help fill out this application? ☐ Yes ☐ No

First Name: _____ Last Name: _____

Email Address: _____ Phone Number: _____

Relationship: _____ May We Contact? ☐ Yes ☐ No

DISABILITY INFORMATION

What is your disability? _____

Date of onset/when your disability first began: _____

Are you currently receiving any treatment? ☐ Yes ☐ No

What treatment(s) are you currently receiving?

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Rehabilitation Program | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> New Medications | <input type="checkbox"/> Non-Walking Cast | <input type="checkbox"/> Walking Cast |
| <input type="checkbox"/> Travel Training | <input type="checkbox"/> Other : _____ | |

If you are currently receiving treatment, how long is the treatment expected to last?

- ☐ 1-3 months
 ☐ 3-6 months
 ☐ 6-9 months
 ☐ 9-12 months
- ☐ Over a year

Describe any side effects you are currently experiencing from the medication/treatment you are receiving:

Please read the following statements and check the one that best describes your disability:

___ I am able to ride the city bus independently.

___ I believe I can ride the city bus if someone taught me how to ride.

- ☐ I can use the city bus for some trips but not others.
- ☐ I have a temporary disability and will only need the LIFT until I recover.
- ☐ I have a visual disability which prevents me from using the city bus.
- ☐ I have difficulty remembering all of the things I have to do to use the city bus.
- ☐ I have a disability that causes me to have good days and bad days.
- ☐ I can never use the city bus by myself.

MOBILITY DEVICES

Do you currently use a mobility device when going places? ☐ Yes ☐ No

If yes, check which mobility device(s) you use:

- ☐ Power/Electric Wheelchair
- ☐ Manual Wheelchair
- ☐ Scooter
- ☐ Sport Wheelchair
- ☐ Walker
- ☐ Service Animal
- ☐ Prosthesis
- ☐ White Cane
- ☐ Crutches
- ☐ Portable Oxygen
- ☐ Communication Board
- ☐ Leg Braces
- ☐ Picture/Alphabet Board
- ☐ Segway
- ☐ Cane
- ☐ None / Other: _____

Is your scooter/wheelchair wider than 30"?

☐ Yes ☐ No ☐ I don't know ☐ NA

Is your scooter/wheelchair longer than 48"?

☐ Yes ☐ No ☐ I don't know ☐ NA

Is the total combined weight of you and your mobility device more than 600 lbs.

☐ Yes ☐ No ☐ I don't know ☐ NA

NOTE: If you use a wheelchair, it may not be larger than 30" wide, longer than 48" long, and your combined weight with your wheelchair may not exceed 600 pounds, or we may be unable to accommodate your trip.

How long have you been using your mobility device?

☐ 1-3 months ☐ 3-6 months ☐ 6-9 months ☐ 9-12 months

☐ Over a year

FIXED ROUTES

Do you use the city bus independently? ☐ Yes ☐ No

If you use the city bus independently, specify which routes you use most often:

First Route:

Destination Name: _____

Destination Address: _____

Route(s): _____

Is a transfer required for this trip? ☐ Yes ☐ No

Second Route:

Destination Name: _____

Destination Address: _____

Route(s): _____

Is a transfer required for this trip? ☐ Yes ☐ No

When was the last time you independently used the city bus?

☐ Last 30 days ☐ Year ☐ 5 years ☐ 10 years ☐ Never

Are there certain days/times you can use the city bus, but not others?

☐ Yes ☐ No ☐ Sometimes ☐ I Don't Know

If you chose Yes/Sometimes, please explain:

Are you able to wait for the city bus?

☐ Yes ☐ No ☐ Sometimes ☐ I Don't Know

If you chose Yes/Sometimes, please explain:

Would you require someone to travel with you when riding a wheelchair-accessible city bus to provide assistance to you?

☐ Yes ☐ No ☐ Sometimes ☐ I Don't Know

If you chose Yes, please explain:

How would you describe the terrain where you live (e.g. flat, hilly, dirt roads, lack of sidewalks)?

Have you ever successfully completed travel training? ☐ Yes ☐ No

If you chose Yes, when and where did you receive the training?

MetroLink Tulsa offers travel training to those who want to learn how to use the city bus. By answering Yes to this question, MetroLink Tulsa may contact you to schedule an appointment. Are you interested in travel training? ☐ Yes ☐ No

ABILITIES

Do you have a hearing problem that would prevent you from using the city bus?

☐ Yes ☐ No

Do you have a visual problem that would prevent you from using the city bus?

☐ Yes ☐ No

Do you have a memory problem that would prevent you from using the city bus?

☐ Yes ☐ No

If you chose Yes, please explain:

Do you have a balance problem that would prevent you from using the city bus?

☐ Yes ☐ No

Do you have a breathing problem that would prevent you from using the city bus?

☐ Yes ☐ No

If you chose Yes, please explain:

Would you have problems waiting at a bus stop? ☐ Yes ☐ No

If you chose Yes, please explain:

Would you have problems counting money and paying the bus driver? ☐ Yes ☐ No

If you chose Yes, please explain:

Would you have a problem independently crossing a street? ☐ Yes ☐ No

If you chose Yes, please explain:

Have you ever been lost when traveling alone? ☐ Yes ☐ No

If you chose Yes, please explain how you found your way back:

How far can you walk (using a mobility device if applicable) or wheel without resting?

_____ Blocks

The following list includes common barriers that prevent people from using the city bus.

Do any of these barriers apply to you?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Rain |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Snow | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Lack of sidewalks | <input type="checkbox"/> Lack of curb cuts | <input type="checkbox"/> Uneven travel path |
| <input type="checkbox"/> Hill | <input type="checkbox"/> Bus stop not accessible | <input type="checkbox"/> Air pollution |
| <input type="checkbox"/> Good / bad days | <input type="checkbox"/> Unable to transfer buses | <input type="checkbox"/> None |
| <input type="checkbox"/> Lack of strength/endurance (hyper fatigue) | | |
| <input type="checkbox"/> Unable to walk/wheel 50 feet (1 block) | | |
| <input type="checkbox"/> Unable to walk/wheel $\frac{1}{4}$ mile (3 blocks) | | |
| <input type="checkbox"/> Unable to walk/wheel $\frac{3}{4}$ mile (9 blocks) | | |

Do you have a home care provider? ☐ Yes ☐ No

Do you do your own shopping? ☐ Yes ☐ No

Have you had a recent fall that required medical attention? ☐ Yes ☐ No

I understand the purpose of this application is to determine if there are times when I cannot use MetroLink Tulsa's fixed-route bus service and may therefore require the LinkAssist Program for my public transportation needs. I certify that, to the best of my knowledge, the information in this application is true and correct. I understand that providing false information may result in denial of service as well as penalty under the law.

By signing this application, I understand I am giving consent for MetroLink Tulsa to use and disclose my protected health information to transfer information to transportation providers and mobility services. I hereby give my permission to MetroLink Tulsa to contact my healthcare provider to verify my disability and treatment plan for purposes of determining paratransit eligibility.

I understand MetroLink Tulsa has the right to review my ADA paratransit eligibility at any time, and where circumstances may warrant, I may become no longer eligible to receive ADA paratransit services.

Signature: _____ Date: _____