



Application for MTS Access Paratransit Service

Informational Sheet

Thank you for inquiring about eligibility for MTS' Access Service. MTS offers multiple public transportation options for people with disabilities. Eligibility for these services is based on an individual's functional ability to use MTS' fixed route service.

MTS operates fixed route bus and light rail trolley services transporting people with physical, cognitive, and visual disabilities on a daily basis. All MTS fixed route buses and light rail trolleys are equipped with ADA accessible features, such as low floor buses, lifts/ramps, audio announcements, designated priority seating areas for people with disabilities, enhanced signage, kneeling buses, and hand rails.

MTS provides a Reduced Fare Program for Seniors, Disabled and people on Medicare (SDM Program). This fixed route program provides discounted fares and is the primary program used by most customers with disabilities in San Diego. Eligible customers can travel on accessible fixed route and light rail trolley at 68% reduced fare on monthly passes. This program is available for people with disabilities who are able to use the bus and light rail trolley systems as their primary travel option.



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For more information on the SDM Program or to obtain an application, please visit: www.sdmts.com/fares-passes/reduced-fare-and-passes or call 619-234-1060.

MTS also provides the MTS Access Paratransit Service for customers with disabilities. Per the Federal Transit Administration (FTA), eligibility for complementary paratransit is directly related to the functional ability of individuals with disability to use fixed route transit services. If you are functionally unable to use the bus and light rail trolley service, you may be eligible for MTS Access. Concerns such as diagnosis, age, distance to bus stop, lack of bus service, overcrowded buses or trolleys, inability to drive, personal finances, inconvenience, and/or discomfort are not the basis of MTS Access eligibility determination.

MTS Access is provided in accordance with the Americans with Disabilities Act (ADA) and is an origin to destination, shared ride, advanced reservation public transit service. Consistent with the ADA, MTS Access is comparable to MTS' fixed route bus and light rail trolley system including service characteristics (such as on time performance and travel time) and service area ($\frac{3}{4}$ mile of a regular MTS fixed bus or light trolley route).



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HOW TO APPLY:

1. Review the eligibility information supplied on this ADA application.
2. If you believe you qualify for ADA paratransit services:
 - a. Complete **Part A** of the application.
 - b. Have a medical professional familiar with your health condition or disability and your functional abilities and limitations complete **Part B** of the application. Part B must be completed within **60 days prior** to the in-person assessment.
3. Once both parts of the application have been submitted, please call 844-299-6326 to schedule an in-person assessment. It is your responsibility to contact us to schedule your in-person assessment.

To apply for new certification or recertification, please submit your application to MTS Access Eligibility at:

Mail: MTS Access Eligibility

100 16th Street

San Diego, CA 92101

or

Fax: 844-299-6369

or

Email: Access@sdmts.com



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or

Online at: www.sdmts.com/access

If you receive assistance completing Part A, that same person cannot also complete Part B. Part A and B must be filled out by different individuals familiar with your disability and/or health condition(s).

WHAT HAPPENS AT MY IN-PERSON ASSESSMENT:

1. Your photo will be taken. If found eligible, MTS Access drivers will use the photo to confirm your identity when getting on the bus.
2. At your appointment, you will have an in-person assessment with a Mobility Assessment Evaluator.
3. Your eligibility determination will be based on:
 - a. Information provided on your application.
 - b. Results from your in-person assessment.
 - c. Supplemental verification provided by your health care professional.
4. You will receive a letter within 21 days of your in-person assessment informing you of your eligibility status. If approved, you will receive a Rider's Guide.



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5. If you are denied unconditional eligibility, you have the right to appeal. You will receive a letter regarding this decision and a copy of the MTS Access appeals process.

We look forward to meeting with you during your in-person assessment.

Location:
Access Eligibility Office
100 16th Street
San Diego, CA 92101

This application is available in alternative formats. If you would like additional assistance, please call 844-299-6326.

Before I start this application and the certification process, I understand all information provided must be true, accurate, and correct. I hereby certify that, to the best of my knowledge, information given in this application is correct. The purpose of this application is to determine if I am eligible to use paratransit services, or if at times, I can ride the MTS fixed route buses and light rail trolleys. I understand that falsification of information could result in a loss of paratransit services as well as a penalty under the law.



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PART A: Applicant Information and Release

An incomplete application will be returned to the applicant and may delay processing. All information must be legible.

Personal Data

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth: _____ Social Security Number: _____

Medi-Cal Number: _____ I do not have Medi-Cal
(if applicable)

If Medi-Cal, Managed Care Provider:

Aetna Better Health of
California

Kaiser

Molina Healthcare of
California

BlueCross BlueShield

Community Health Group

United Healthcare

Health Net

Home Phone: _____

Phone: _____

Other Phone: _____

Gender: Male Female

Do you require Yes No
TDD services?



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Email Address: _____

Mailing Address: _____

City _____ State _____ Zip _____

Home Address: _____

City _____ State _____ Zip _____

New Application Recertification

If recertification: ID Number: _____

Exp. Date: _____

Please give us the name and phone number of a friend or relative we can call in case of emergency or if we are unable to reach you at your regular number:

First Name: _____

Last Name: _____

Phone: _____

Other Phone: _____

Relationship: _____



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Transit Usage

1. Do you currently use fixed route (large public) bus or light rail trolley independently? Yes No Sometimes

Fixed Route Bus? Yes No Sometimes

Light Rail Trolley? Yes No Sometimes

2. When was the last time you rode the fixed route bus or light rail trolley independently?

3. How frequently do you ride the fixed route bus or light rail trolley? _____ per month

4. Which fixed route bus routes or light rail trolley lines do you use? _____

5. Please provide your 20-digit PRONTO Card number: _____

I do not have a PRONTO Card

6. Have you ever had travel training to learn how to travel around the community and/or on how to use fixed route buses or light rail trolleys? Yes No

7. Would you like information about travel training to use the fixed route buses or light rail trolleys? Yes No

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Disability/Health Condition Information

All questions must be answered.

8. Please describe the disability or health condition which prevents you from using fixed route buses and light rail trolley service.

9. Is this a temporary disability or health condition? Yes No

10. If yes, how long you do expect it to prevent you from using fixed route buses and light rail trolley service? _____ Months

11. Are you currently receiving any treatment? Yes No

If yes, check what treatment(s) apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Convalescence |
| <input type="checkbox"/> Non-weight Bearing Immobilization | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Weight Bearing Immobilization | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Dialysis | |
| <input type="checkbox"/> Other: _____ | |

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12. How long will you be receiving treatment?

- | | | |
|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> < 3 months | <input type="checkbox"/> 3-6 months | <input type="checkbox"/> 6-9 months |
| <input type="checkbox"/> 9-12 months | <input type="checkbox"/> > 12 months | <input type="checkbox"/> Unknown duration |

13. Have you had a recent fall which required medical attention?

- Yes No

If yes, what is your fall frequency per week?

If yes, did the fall occur while using mobility aid/device?

- Yes No

14. Do you live in an assisted living facility or nursing facility?

- Yes No

15. Do you ever need to bring someone with you to help you when you travel (a “personal care assistant” or “personal attendant”)?

- Yes No

16. Do you use any mobility aids or equipment?

(check all that apply)

- None

- | | |
|--|--|
| <input type="checkbox"/> Powered/Electric Wheelchair | <input type="checkbox"/> Communication Board |
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Portable Oxygen in Cart |
| <input type="checkbox"/> Powered Scooter | <input type="checkbox"/> Portable Oxygen in Bag |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Brace - <i>Type of brace:</i> |
| <input type="checkbox"/> White Cane | _____ |

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Other Mobility Device(s) used:

17. If you use a wheelchair or scooter, what is the width and length?

Width: _____ inches

Length: _____ inches

18. If you use a wheelchair or scooter,
what is the total weight of your mobility
device when you are using it?

_____ pounds

If your wheelchair or scooter is larger than 30 inches wide, 48 inches long and 800 pounds when occupied, the MTS paratransit vehicle may be unable to accommodate your trip.

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Transit Skills

Please read the following statements and check those which best describe your abilities to use fixed route buses or trolleys (check all that apply). **At least one box needs to be checked.**

- I can get to and from bus stops or light rail trolley stations if the distance is not too great.
- I can ride buses and light rail trolleys when I am feeling well. There are other times, when my disability or health condition worsens, that I cannot ride the buses and trolleys.
- I have a disability or health condition that prevents me from riding the buses and light rail trolleys if the weather is very hot or cold.
- I can grasp railings and money to pay the fare on the buses and light rail trolley.
- I can get to and from bus stops and light rail trolley stations only if there are curb cuts and sidewalks.
- I can get to and from bus stops and light rail trolley stations only if there are no hills.
- I have difficulty understanding or remembering all the things I would have to do to use the buses and light rail trolleys.
- I can use the buses and light rail trolleys if it is someplace that I go all of the time.
- I can never use buses and light rail trolleys by myself.



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- I am not sure if I can use buses and light rail trolleys.
- I am not able to use buses and light rail trolleys for other reasons.

If you checked any of the above boxes, please explain:

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Functional Skills

The following questions will give us more information about your functional abilities. Please select Always (A), Sometimes (S), or Never (N) in response to the following questions and provide an explanation.

Without the help of someone else can you:

Ask for and understand written or spoken instructions? A S N

If Sometimes or Never, please explain: _____

Cross the street? A S N

If Sometimes or Never, please explain: _____

Stand for 15 minutes if there is no place to sit? A S N

If Sometimes or Never, please explain: _____

Step on and off a sidewalk from a curb? A S N

If Sometimes or Never, please explain: _____

Walk up and down three steps if there is a handrail? A S N



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If Never, please explain: _____

Walk on uneven surfaces?

A S N

If Never, please explain: _____

Stand on a moving bus or trolley if there is a handrail?

A S N

If Never, please explain: _____

Transfer from one bus or light rail trolley to another?

A S N

If Never, please explain: _____

Under the best conditions, what is the farthest that you can travel outdoors (using your mobility aid if you use one) without the help of another person? < 1 block 1-4 blocks > 4 blocks



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Please provide any other information about your disability or health condition that would help us better understand your travel abilities:



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Certification

I hereby certify that, to the best of my knowledge, information given in this application is correct. The purpose of this application is to determine if I am eligible to use paratransit services (MTS Access), or if I can ride the MTS fixed route buses and light rail trolleys. I understand that falsification of information could result in a loss of paratransit services as well as a penalty under the law. I agree to undergo an in-person assessment of my mobility abilities and limitations for the purpose of making a determination regarding my eligibility for paratransit service. I understand that intentionally providing false or misleading information or a refusal of an in-person assessment is grounds for a determination of ineligibility for MTS Access services and benefits. I agree to notify MTS if my condition changes, if I am using a new mobility device, or if I no longer need to use ADA paratransit service.

Applicant/Responsible
Party Signature:

Date:



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Authorization for Release of Information

I _____ authorize my health care professional to release any and all information about my disability or health condition and its effect on my ability to travel on the MTS bus and light rail trolley system (**Part B**). I understand that I may revoke this authorization at any time. I understand that MTS Staff or the ADA Certification Contractor may contact the health care professional who completed the verification attached to this application, in order to confirm this information. I understand that all medical information will be kept strictly confidential.

Applicant/Responsible

Party Signature: _____ Date: _____

If someone assisted in completing this application, please provide the following information:

Print Name: _____

Agency (if applicable): _____

Relationship to Applicant: _____

Address: _____

Home Phone: _____ Other Phone: _____

Signature: _____ Date: _____

Please make a copy for your file