

# APPLICATION FOR ACCESS

Please return to:

Trinity Metro ACCESS - 800 Cherry Street, Fort Worth, Texas 76102

Phone: (817) 215-8600 | Fax: (817) 215-8934

For Office Use Only	
Date Received	_____
I.D.#	_____
Status Code	_____
PCA	_____
Mapsco Grid	_____

## SECTION 1

To be completed by applicant. Please type or print.

Have you ever been certified to use ACCESS? YES  NO  Date of Birth \_\_\_\_\_

If no, have you ever applied for ACCESS? YES  give date \_\_\_\_\_

1. Name: Mr  Ms  \_\_\_\_\_  
First Initial Last

2. Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Area Code Area Code

3. Home Address: \_\_\_\_\_  
Street or Box # City State Zip

Apartment Name & Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(If different) Street or Box # City State Zip

4. Language Preference: English  Spanish  Braille  Large Print  Audio  English Spanish  
circle audio language preference

5. Emergency Contact: \_\_\_\_\_  
Name Relationship Daytime Phone

Address: \_\_\_\_\_  
Street or Box # City State Zip

6. Assistive device used? Check all that apply:

Manual Wheelchair  Electric Wheelchair  Powered Scooter  Portable Oxygen   
Cane  Crutches  Walker  Prosthesis  Mobility/White Cane

Service Animal  What service does animal provide? \_\_\_\_\_

7. If you use a wheelchair or scooter, does your residence have a wheelchair ramp? Yes  No

If No ramp, how many steps? \_\_\_\_\_ (Driver will not take a wheelchair up or down a step higher than 6" or more than one step)

If more than one step, how do you transport your wheelchair to street level? \_\_\_\_\_

8. If necessary, can you transfer yourself from a wheelchair to a passenger car? Yes  No

9. Have you ever used the city bus service? Yes  No

Have you ever had training to use the city bus service? Yes  No

Most frequent destinations - list addresses: \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant Name: \_\_\_\_\_  
(for fax transmissions)

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NBR \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(required) Month Day Year

### SECTION 2

Must be completed by Agency or Physician. Please type or print.

Please remember that the paratransit program is a subsidized shared ride service that provides transportation to persons who have a disability that **PREVENTS** use of the existing public transit. Also keep in mind that we have a high volume of individuals who are interested in service, but the purpose of paratransit is for those qualified **persons whose only option for transportation is paratransit**. If you have questions regarding eligibility, please call the ACCESS office at 817-215-8600. All final decisions regarding eligibility are made by the ACCESS administrative staff.

10. What is the medical diagnosis that causes the disability?

(i.e., if intellectual disability - list I.Q., seizures - list type, frequency/number per month)

\_\_\_\_\_  
Date of diagnosis: \_\_\_\_\_

11. How does the disability prevent the applicant from riding regular city bus service?

What are their physical limitations?

\_\_\_\_\_  
\_\_\_\_\_

List any medications that may impair or aid with mobility: \_\_\_\_\_

Is there any therapy pending? Yes  No  Expected Results: \_\_\_\_\_

If the person has a disability affecting mobility, is this person: (check all that apply)

Able to walk or wheel self without assistance? Yes  No   
>1 Block  1 Block  3 Blocks  6 Blocks  9 Blocks  (3 blocks = 1/4 mile)

Remarks \_\_\_\_\_

Using a handrail, is applicant able to climb three 12 inch steps without assistance? Yes  No

Remarks \_\_\_\_\_

Able to wait outside in all weather conditions without support for at least 20 minutes? Yes  No

Remarks \_\_\_\_\_

If vision impaired, what is Best Corrected Visual Acuity (Snellen)?

Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_ Field Restriction: Right \_\_\_\_\_ Left \_\_\_\_\_

12. Does this person use any assistive devices? If so, what? \_\_\_\_\_

Has this person ever had training to use the city bus service? Yes  No  Do Not Know

Could this person use regular city bus service? Never  Sometimes  Always  if wheelchair accessible \_\_\_\_\_

Could this person benefit from Bus Route training? Yes  No

13. Is disability: Permanent  Temporary  If temporary, how long will applicant need service? \_\_\_\_\_

14. All certified applicants are allowed to take a guest with them. Is the applicant required to have a personal care attendant to administer assistance with them? Yes  No

If needed, applicant must provide their own attendant.

\_\_\_\_\_  
Verifying Agency or Physician ( ) Area Code Phone / Fax

Address City State Zip

15. I (PRINT NAME) \_\_\_\_\_ SIGNATURE DATE  
CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Any additional information may be attached. Thank you for taking the time to complete this application.