APPLICATION FOR ACCESS

For Office Use Only
Date Received________
I.D.#________
Status Code________
PCA________
Mapsco Grid________

Please return to:
Trinity Metro ACCESS - 801 Grove Street, Fort Worth, Texas 76102
Phone: **(817) 215-8600** | Fax: **(817) 215-8934**

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

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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 ________

(NOTE: Once we have received a completed application with all required information, it may take up to 21 days to process it.)

Applicant Name: ______________________________
(for fax transmissions)

Date of Birth: ______ / ______ / ______
(required) Month Day Year

For Office Use Only
NBR________________

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)** ______________________________ ______________ ________
CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. **SIGNATURE** **DATE**

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