

APPLICATION FOR ACCESS

Please return to:

Trinity Metro ACCESS - 801 Grove 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 _____



(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)

For Office Use Only
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.