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: (____) _____ (Area Code) Cell Phone: (____) _____ (Area Code)

   Email Address: _____

3. Home Address: _____ (Street or Box # / City / State / Zip)

   Apartment Name & Number: _____
   (If different)
   Mailing Address: _____ (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** _____

TRINITY METRO®

(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.