MetroWest Regional Transit Authority

Dial-A-Ride SERVICE APPLICATION

For residents of the towns of Ashland, Hopkinton, Marlborough, Southborough and Wayland.

(Disabled under 65)

Part A: Applicant information: (Please print)

Name:_____Date: _____

Address: _____

City:_____State:_____Zip: _____

Date of Birth:_____Telephone: _____

Emergency Contact:_____Relationship: _____

Telephone: _____ Cell:_____ W: _____

Please list any Mobility Aids: (Wheelchair, Cane etc…)

_____

If any of the following apply, simply complete Parts A and B.

- Medicare card holder
- Current recipient of services through the Massachusetts Department of Mental Health ***(restrictions may apply)***
- Current recipient of services through the Massachusetts Department of Mental Retardation ***(restrictions may apply)***
- Veteran with a disability rating of 70% or greater
- Current customer of THE RIDE

MetroWest Regional Transit Authority Call Center
15 Blandin Ave, Framingham, MA 01702
(508) 820-4650 * Fax: (508) 935-2940
TTY (508) 935-2242

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Part B: To be completed by applicant: ***check only <u>one</u>***

☐ I am a Medicare card holder. <u>I have attached a copy of my medicare card.</u>***(*Please note:** MassHealth and Medicaid are not the same as Medicare.)***

☐ I am a current recipient of services through the Massachusetts Department of Mental Health (DMH) and /or Department of Mental Retardation (DMR). I have attached an original letter from an authorized representative of DMH/DMR which confirms my status as a client. ***(restrictions may apply)***

☐ I am a veteran with a disability rating of 70% or greater. I have attached an original letter from the VA, signed by a Veteran's Service Officer, which specifies my disability rating.

☐ I am a current customer of the MBTA RIDE/MWRIDE service
My RIDE ID # is: _____

If you checked one of the above boxes, then you do <u>not</u> need to have Part C completed.

If you do not qualify under the categories above, you must bring this application to a licensed health care professional to complete **Part C. An example of a licensed health care professional would include someone who is familiar with your disability, such as a medical doctor, nurse practitioner, psychologist, registered nurse, social worker, or audiologist.*

Once the application is complete, return to the address below:

You will be contacted once your application has been reviewed and eligibility is determined.

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I agree to release this information to MetroWest Regional Transit Authority for the purpose of determining eligibility for Dial-A-Ride service. MetroWest Regional Transit Authority reserves the right to contact the licensed professional completing this application.

SIGNATURE OF APPLICANT: _____

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Part C: Health Care Certification

To be completed by a licensed health care professional:

Please answer all applicable questions thoroughly on this page. Review and complete the "Guidelines for Health Care Professional" on the next page. Eligibility for this applicant will be determined based on the information you provide. ***NOTE:*** *A person is not considered transportation disabled if his/her sole incapacity or disability is pregnancy, obesity, impairment due to drugs or alcohol or controlled epilepsy.*

Health Care Professional's Name: (Please print) License Number/State

_____ _____

Business Address: City: State: Zip:

_____ _____ _____ _____

Telephone:_____ Licensure Title: _____

What is the applicant's disability(s)? Please refer to page 5 for guidelines.

(Please print or type)

_____

_____

Are there any limitations caused by the disability?

_____

_____

Is this person's disability temporary? _____ Yes _____ No
What is the duration of this person's disability? _____

Please list any mobility devices the individual uses. _____

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Guidelines for Health Care Professionals:

Please indicate below which of the categories apply to the applicant. Be sure to include any additional information we request.

1. Non - ambulatory disabilities – those who require the assistance of a wheelchair.
2. Semi – ambulatory disabilities; i.e. those who require the use of a walker, crutches or a leg brace.
3. Musculoskeletal conditions such as muscular dystrophy, osteogenesis imperfect or rheumatism restrictions. Please specify therapeutic grade according to ARA, and indicate which limbs are affected.
4. Amputation of an extremity. Please specify which limb(s) are affected .
5. Severe effects from CVA (stroke). Eligible conditions include functional motor deficit affecting any two limbs or ataxia 4 months post cva.
6. Severe pulmonary conditions that affect mobility.
7. Severe cardiac conditions. Please include functional class of impairment and therapeutic grade as defined by the N.Y. Heart Association.
8. Persons requiring kidney dialysis treatment.
9. Vision impairments (those whose visual acuity in the better eye after correction is 20/200 or worse, or visual field is contracted (tunnel vision).
10. Hearing impairments (deafness or hearing loss of 90 db or greater in the 500, 1,000 and 2,000 hz ranges.)
11. Coordination disabilities. (those persons with a functional motor deficit in any two limbs or who experience manifestations which significantly reduces mobility, coordination and/or perception.)
12. Mental Retardation.
13. Cerebral Palsy. Please indicate the extent of difficulty in motor function.
14. Epilepsy. Please include severity and frequency of seizure activity despite medication.
15. Autism. Please indicate severity.
16. Neurological disabilities. Indicate how perceptual and behavioral functioning is affected (Please include nature of condition and etiology.)
17. Mental Disabilities. This section applies only to those persons with a significant psychiatric impairment covered by the DSM IV with temporary or long term limitations to daily life functioning. (please include extent of difficulty and DSM IV diagnosis.)
18. Progressive Illnesses. Including Acquired Immune Deficiency Syndrome, and/or cancer. The disease must impact the performance of the applicant's organic system so the symptoms produced fall within one of the above categories.

Which of the above categories best describe this applicant's disability? _____

Please provide us with any additional information that you feel would help us make our decision regarding eligibility.

_____

Licensed Health Care Professional: Please sign below:

I hereby claim that the above information is accurate and true to the best of my knowledge.

_____ Date: _____

The above named hereby signs this document under the pains and penalties of perjury.

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