What is Paratransit?

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President/CEO
VIA Metropolitan Transit
Para + Transit

similar but distinct from

fixed-route traditional service
How is Paratransit distinct?

• Requires customer interaction to get service
• Does not limit to fixed-route stops
By any other name …

- Demand-response service
- ADA complementary paratransit service
- Mobility-on-Demand service
- Rideshare (vans, carpools, TNC)
- Jitney
In Urban Settings

- ADA complementary paratransit
- Mobility-on-Demand
- Rideshare matching
In Rural Settings

- Demand-response service to the general public
Examples from VIA

VIAtrans

VIA Link

VIA Vanpool
Paratransit Transportation Solutions for Texans with Disabilities

Paratransit Eligibility

Metropolitan Transit Authority of Harris County (Houston METRO)

December 2021
How is Paratransit Eligibility Determined?

Disability alone does not determine paratransit eligibility; the decision is based on the applicant’s functional ability to use the fixed route bus and is not a medical decision.

The Department of Transportation (DOT) Americans with Disabilities Act (ADA) regulations in Appendix D to 49 C.F.R. Section 37.125 explain: “The substantive eligibility process is not aimed at making a medical or diagnostic determination.
How is Paratransit Eligibility Determined?

While evaluation by a physician (or professionals in rehabilitation or other relevant fields) may be used as part of the process, a diagnosis of a disability is not dispositive. What is needed is a determination of whether, as a practical matter, the individual can use fixed route transit in his or her own circumstances.”

Transit agencies, with input from the communities they serve, devise the specifics of their individual eligibility processes. The DOT ADA regulations in Section 37.125 set only broad requirements that all agencies must incorporate, such as written notification of eligibility decisions and an opportunity for an appeal.
Eligibility Categories

1. The person cannot navigate the system independently

2. The person needs an accessible vehicle

3. There are obstacles which prevent the person from accessing the bus or rail system
Types of Eligibility Granted by the Transit Agency

Unconditional Eligibility

Conditional Eligibility

Temporary Eligibility
Application Process

Application for METROLift Service

Instructions: On pages 1 – 4 of this application, METROLift is asking for information about you and your ability to use METRO bus service. Please take the time to answer ALL questions carefully and completely. We cannot determine your eligibility for METROLift service without this information. A friend, guardian, caregiver, agency service representative or family member may help you complete your portion of the application, pages 1-4. Accurate information is required about you, your medical impairment, and your functional capacity. Pages 5 - 6 must be completed and certified by a physician/certified health professional who is familiar with your impairment or condition.

If you have questions, please call METROLift Customer Service at 713-225-0119.

Have you ever applied for METROLift?  No  Yes

TO BE COMPLETED BY APPLICANT

Name of Applicant  Last/Apellido  First/Nombre  Middle/Nombre  Social Security Number (ONLY last 4 digits)

Address/Street / Dirección/Calle  Apartment Number/Apellido de Apartamento  City/Ciudad  Zip Code/Código Postal

Date of Birth/Fecha de Nacimiento  Home Phone Number/En Casa Número de Teléfono  Other Phone/Otro Teléfono

Applicant Signature (required)  Firm  Date/Fecha

Name of Emergency Contact/Contacto de Emergencia  Relationship/Relación  Emergency Phone/Número de Emergencia
Application Process

INDIVIDUAL AND MOBILITY INFORMATION

1. Please state your disability(s).

2. What assistive device(s) do you use when traveling? (Please check all that apply.)
   - Support Cane
   - Manual wheelchair
   - Trained service animal
   - Crutches
   - Powered wheelchair
   - Communications device
   - Walker
   - Power scooter
   - “White cane”
   - Leg brace(s)
   - Portable oxygen
   - None
   - Other (describe)

3. What is the nearest street intersection to your home? (Example: Polk & Wayside)

4. Can you walk or use your wheelchair or assistive device(s) from your home to that intersection without assistance?  □ Yes    □ No
   If “no,” please explain.

5. Can you find your way to a bus stop without getting lost?  □ Yes    □ No
   If “no,” please explain.

6. How long can you stand and wait for a bus?
   - □ 15 minutes
   - □ 10 minutes
   - □ 5 minutes
   - □ Less than 5 minutes

7. All buses have a “destination sign” in front, which shows the route name and number.
   - Can you read a bus destination sign?  □ Yes    □ No
   - Can you ask the driver where the bus is going?  □ Yes    □ No
   - Can you give or write a note to the driver?  □ Yes    □ No
   - Can you understand the driver’s answer?  □ Yes    □ No
   If “no” to any questions, please explain.
Application Process

8. If you were on the bus, could you pay the fare by putting money in the fare box, or by tapping the METRO Q Card on the Q box? [ ] Yes [ ] No
   If "no," please explain

9. If you were on the bus, could you recognize the place where you wanted to get off the bus?
   [ ] Yes [ ] No
   If "no," please explain.

10. Please tell us about the times when you can use METRO's local fixed-route bus service? (Example: if short distance to bus stop; take attendant; need to get somewhere.)

11. Have you ever received "orientation and mobility training" or "travel training?" [ ] Yes [ ] No
    If "yes," please list any METRO bus routes on which you can travel:

12. Please tell us the reasons you feel you cannot use METRO's local fixed-route bus service for some or all trips.

13. How do you currently travel (self, family, friends, bus, rail, METROLift, etc.)? Please explain.

14. Do you require someone to travel with you? [ ] Yes [ ] No
    If "yes," please explain

15. Can you wait independently alone at your residence and places to which you travel? [ ] Yes [ ] No
    If "no," please explain.
AGREEMENT AND AUTHORIZATION:

I state that the information I have provided is true and accurate.

I authorize the release of diagnostic and functional information as requested on pages 5 and 6 to METRO for the sole purpose of making a determination regarding my eligibility for paratransit service (METROLift) and understand that personal and medical information will be kept confidential.

I understand that intentionally providing false or misleading information or refusal to undergo an in-person interview assessment is grounds for denial of METROLift services.

If approved, I agree to follow the rules and guidelines established by METROLift and to promptly inform METROLift of any changes in my residence, phone number and, if applicable, my representative’s name and phone number, and any significant change in my condition that would affect my level of mobility.

I understand that failure to follow proper procedures or cooperate with METROLift staff, demonstrating illegal or disruptive behavior or, if my condition at any time poses a direct threat to the health or safety of others, such situations may result in either suspension and/or termination of service.

Applicant’s Signature: ________________________ Date: ________________________

If someone other than the applicant is preparing this form, please provide the following information about the preparer:

Name: (please print) ________________________

Day Phone: ________________________ Relationship: ________________________

Preparer’s Signature: ________________________ Date: ________________________
Dear Physician or Healthcare Professional:

We need your assistance in determining eligibility for services provided by METROLift to persons with disabilities who are unable to use local bus transportation. We are seeking specific information as to what prevents the person from using METRORail and the METRO bus routes that provide transportation throughout the area. METRO buses are equipped with ramps, lifts, and kneeling features to assist boarding as well as automatic announcements of major stops to help riders know where they are along the route. The Americans with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states—"each public entity operating a fixed route system shall provide paratransit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed route system." By complementary, DOT means service for individuals with disabilities who cannot use the fixed route bus system. The information requested of you in the following sections will be used to help determine the applicant’s METROLift eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Have you previously seen this patient?  [] Yes  [] No

2. Please rate (Excellent / Good / Fair / Poor / None / Don’t Know) the applicant in terms of:

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<th>Excellent</th>
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3. In your opinion, can the applicant travel independently from his/her house to the sidewalk?  [] Yes  [] No  [] Sometimes

   If "no" or "sometimes," please explain. ____________________________________________

4. Can the applicant walk up and down two steps?  [] Yes  [] No  [] Sometimes

5. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant independently travel without assistance?  [] less than 1/4 mile  [] 1/4 mile  [] 1/2 mile  [] 3/4 mile  [] more than 3/4 mile
Application Process

6. Does the applicant’s disability require him/her to travel with another person who provides personal assistance?  ☐ Yes ☐ No ☐ Sometimes

7. Please provide medical diagnoses in layman’s terms to describe the applicant’s primary impairments or disabling conditions.


8. We are seeking specific information as to what prevents your patient from accessing the local bus and rail system.


9. Is the condition ☐ Permanent or ☐ Temporary (months) __________

10. If visually impaired, what is the applicant’s best corrected acuity?
    (Snellen)? (R) __________ (L) __________
    Field Restriction: (R) __________ (L) __________ Date of Testing: __________

11. If cognitively impaired, what is the applicant’s cognitive age, and IQ level?


12. Is the applicant a wheelchair user?  ☐ Yes ☐ No If yes, how often __________

13. Does the applicant use other mobility aids?  ☐ Yes ☐ No If yes, please describe.


PHYSICIAN OR HEALTH CARE PROFESSIONAL’S CERTIFICATION:

I certify that the information I have provided herein is a fair representation of this applicant’s medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant’s eligibility for paratransit services. I also agree that METROLift may contact me for clarification of any information I have provided and that I will reply in good faith.

Physician’s/Health Professional’s Full Name __________________________
Institution/Facility/Agency Name __________________________
Street Address ______________ Suite # ______
City ______________ State ______________ Zip Code ______
Medical/Social Worker’s License Number ______ Telephone # ______ Fax # ______
Physician’s/Health Professional’s Signature __________________________ Date ______

***Note: Additional signature of physician/healthcare professional on his/her letterhead or prescription verifying completion of application is required.***

Page 6
In-Person Interviews and Functional Assessments
In-Person Interviews and Functional Assessments
Appeals Process

NOTICE OF APPEAL FOR ADA PARATRANSIT ELIGIBILITY

I, ____________________________, wish to appeal the paratransit eligibility decision:

☐ Eligibility to use the METROLift service was denied - Appealing for ADA Paratransit eligibility
☐ Temporary eligibility was granted - Appealing for longer ADA Paratransit eligibility

Therefore, I am requesting to file an appeal with the Appeals Hearing Officer.

Signature: ____________________________ Date: ____________

Name: _______________________________ METROLift ID #: __________________
Address: ______________________________
City, State, Zip code: __________________________
Telephone: ____________________________

Your appeal must be received within 60 days of notification of eligibility determination. See instructions on the opposite side of this form for alternative ways to appeal without using this form.

(over)

Process for Eligibility Appeals

Appeals are conducted by the Appeals Hearing Officer, who is an advocate for people with disabilities. You have the right to file an appeal and may also request for an in-person hearing or a telephone hearing. All in-person and telephone hearings must be scheduled with the Appeals Coordinator.

To file an appeal you have several options:

- Call METROLift Customer Service at 713-223-0119, Appeals = menu option 3, Monday-Friday 8:00AM-5:00PM
- Complete and return the Notice of Appeal form included in your letter
- Write your own letter notifying METRO of your intent to appeal

These are options; you do not have to file a written appeal. All of these options provide an opportunity to be heard and to be present information and arguments why you believe your suspension should be changed. If you decide to file an appeal via mail or if you decide to submit additional documentation as part of your appeal, please send items to the following address:

METROLift Suspension Appeals
P.O. Box 61425
Houston, TX 77226-1425
Or fax to: Attention Appeals Department at 713-718-8000

The decision of the Appeals Hearing Officer is final. Petitioners have the right to use the service if the Hearing Officer has not made a decision within 30 days of the completion of the appeals process.
Travel Training
Travel Training
Engagement with your Local Transit Agency

METROLift Advisory Committee

METRO Accessible Taskforce

Community Leaders’ Briefing Team
METRO’s Board of Directors