MARTA MOBILITY PARATRANSIT ELIGIBILITY
APPLICATION FOR CERTIFICATION
PART A

DEAR APPLICANT:

This application for certification is the first step in the process that will be used to determine your eligibility for MARTA Mobility Paratransit Services. MARTA Mobility Paratransit Service is an **origin to destination** public transportation service for individuals with disabilities who are prevented from using MARTA's Fixed Route transportation services. MARTA's Fixed Route services include bus and rail transit services. MARTA's bus and rail services are fully accessible to individuals with disabilities. MARTA's Mobility Paratransit Services and Fixed Route Services operate in Fulton, Dekalb and Clayton Counties and in the City of Atlanta.

Please be sure to do the following:

- You **must complete the entire PART A** of the application and answer every question.
- Incomplete applications cannot be processed and will be returned.
- You must have **PART B completed by your Health Care Professional** who can appropriately answer questions about your disability and ability to travel. Your Health Care Professional **must complete ALL sections** of the PART B form.
- You must return both PART A and PART B as the **first step** of the Certification Process.
- Please be sure that both PART A and PART B are completed and signed before returning.

SECTION 1 - APPLICANT GENERAL INFORMATION (PLEASE PRINT)

New Applicant [ ] **Re-certification Applicant** [ ]

Last Name _____ **First Name** _____ **MI** ___ **Title** ___

Street Address: _____

City_____ **State**_____ **Zip**_____ **County**_____

Subdivision/Apartment Complex Name/Gate Code _____

Nearest major intersecting street: _____

Cell Phone# _____ **Home Phone#** _____**Work#** _____

DOB: _____

SECTION 2 - INFORMATION ON DISABILITY & MOBILITY EQUIPMENT

Please be sure to complete ALL of the below information

Please list by name the disabilities or health related conditions which prevent you from using MARTA's Fixed Route Bus and Rail Services:

Is this condition temporary? Yes [ ] No [ ] if yes, how long do you anticipate your disability will affect you.

How does this condition affect your ability to ride regular fixed route bus and train service?

Do any of the following conditions affect your travel?

Hills _____ No Curb Cut _____ No Sidewalk _____

Do you use a mobility device to travel? Please check all that apply:
____ Walking Cane
____ White cane
____ Orthopedic cane (three or four prong base)
____ Walker
____ Braces
____ Crutches
____ Manual Wheelchair
____ Motorized Wheelchair
____ Scooter
____ Portable Oxygen

Do you use a service animal? Yes [ ] No [ ] if yes, what type of animal and for what purpose was the animal trained?

Do you travel with portable medical equipment? Yes [ ] No [ ]
What type of equipment?

Do you require someone to travel with you to provide personal transportation assistance?
Yes [ ] No [ ] Sometimes [ ]

How do you currently travel?

Have you ever been trained in the use of MART A's bus and rail system?
Yes [ ] No [ ]

If yes, where? _____

Do you feel that you could ride the train or bus if the van could get you there and pick you up from there? _____

To the best of my knowledge, the information I have provided in **PART A** of this application has been properly recorded. I have reviewed all answers and certify that the information is complete and correct. I understand that any intentional false or misleading information may be grounds for denial of service.

Signature of applicant _____ Date _____

Representative or legal guardian _____

In case of emergency contact (if possible, alternative number, other than your home phone):

Name *(please print)* _____ Phone# _____

If this application has been completed by someone other than the applicant, that person must complete the following:

Name _____ **Relationship** _____

Address _____

Home phone _____ **Work** _____ **TDD/TTY** _____

I certify, to the best of my knowledge, that the information provided in this application is complete: and correct based upon the information given me by the applicant or my own knowledge of the applicant's health condition or disability.

Signature _____ Date _____

If you would like for your Health Care Provider to receive an electronic version of the PART B application, please provide the following information:

Name of Health Care Provider: _____

Email Address of the Health Care Provider: _____