



Brownsville, TX 78520  
Fax # 956-574-6675

Email:  
cynthia.marroquin@brownsvilletx.gov  
Website: www.brownsvilletx.gov/599/ADA-  
Paratransit-Service

## ADA PARATRANSIT ELIGIBILITY & RECERTIFICATION APPLICATION INSTRUCTIONS

All City of Brownsville Metro fixed route vehicles meet applicable American's with Disabilities Act (ADA) of 1990 requirements and are accessible for persons who use mobility aids. In accord with ADA, the City of Brownsville also operates an ADA Paratransit Service for people with disabilities who are not able to ride fixed route public transportation. B-Metro provides a curb-to-curb service for qualified individuals with disabilities. For more details and/or qualification information, please contact Paratransit Services at 956-541-8381 or [711 or 800-735-2989] (TTY—Texas Relay).

Step  
1

- You or a helper complete **Part 1 – All About You.**
- Include a **picture** of all mobility devices.



- Your healthcare professional completes **Part 2 – Medical Professional.**

- **The applicant MAY NOT complete this section.**



***It is very important for you and your healthcare provider to thoroughly answer each question on the application.***

Step  
2

Once **ALL** paperwork is complete, you may either:

- |                                                       |                                            |
|-------------------------------------------------------|--------------------------------------------|
| • Mail to or deliver in person to:                    | Email to:                                  |
| <b>Brownsville Metro</b>                              | <b>Cynthia Marroquin at</b>                |
| <b>755 International Blvd. (2<sup>nd</sup> Floor)</b> | <b>cynthia.marroquin@brownsvilletx.gov</b> |
| <b>Brownsville, TX 78520</b>                          |                                            |

Step  
3

You will receive your eligibility determination within 21 working days from the date **ALL** of the following are completed:

- Original full application received with signatures required
- Any additional requested information is received by staff

**A written determination of eligibility will be made within 21 days following the application submission. If a decision on eligibility is not made within 21 days, the applicant is considered "conditionally eligible" and may use the ADA Paratransit Service starting on the 22nd day until a final determination is made. Thank you!**

**All information received in this application will be kept CONFIDENTIAL.  
Thank you for your support.**

## SOLICITUD DE ELEGIBILIDAD Y RENOVACIÓN DE PARATRANSITO DE ADA INSTRUCCIONES

Todos los vehículos de ruta fija del Metro de la Ciudad de Brownsville cumplen con los requisitos de la Ley de Discapacidades (ADA, por sus siglas en inglés) de los Estados Unidos aplicables de 1990 y son accesibles para las personas que usan ayudas de movilidad. De acuerdo con ADA, la Ciudad de Brownsville también opera un Servicio de Paratransporte ADA para personas con discapacidades que no pueden viajar en transporte público de ruta fija. B-Metro ofrece un servicio de acera a acera para personas calificadas con discapacidades. Para obtener más detalles y / o información sobre las calificaciones, comuníquese con Paratransit Services al 956-541-8381 o al [711 o 800-735-2989] (TTY: Texas Relay).

Paso  
1

- Usted o un ayudante completan la **Parte 1: Todo sobre usted.**
- Incluya una **imagen** de su dispositivo o dispositivos de movilidad.
- Su profesional de la salud completa la **Parte 2 - Profesional médico.**
- **El solicitante NO PUEDE completar esta sección.**



***Es muy importante que usted y su proveedor de atención médica respondan a fondo cada pregunta de la solicitud.***

Paso  
2

Una vez que TODA la documentación esté completa, puede:

- Envíe por correo o entregue en persona a:

**Brownsville Metro  
755 International Blvd. (2<sup>do</sup> piso)  
Brownsville, TX 78520**

Paso  
3

Recibirá su determinación de elegibilidad dentro de los 21 días calendario a partir de la fecha en que se completó **TODO** lo siguiente:

- Solicitud completa original recibida con firmas requeridas
- Cualquier información adicional solicitada es recibida por el personal

**Se realizará una determinación por escrito de elegibilidad dentro de los 21 días posteriores a la presentación de la solicitud. Si no se toma una decisión sobre la elegibilidad dentro de los 21 días, el solicitante se considera "condicionalmente elegible" y puede usar el Servicio de Paratransporte de la ADA a partir del día 22 hasta que se tome una decisión final.**

**¡Gracias!**

**Toda la información recibida en esta solicitud se mantendrá CONFIDENCIAL.**

**Gracias por su apoyo.**



Brownsville, TX 78520  
Fax # 956-574-6675

Email:  
cynthia.marroquin@brownsvilletx.gov  
Website: www.brownsvilletx.gov/599/ADA-  
Paratransit-Service

## ADA PARATRANSIT ELIGIBILITY & RECERTIFICATION APPLICATION (SOLICITUD DE ELEGIBILIDAD Y RENOVACIÓN DE PARATRANSITO DE ADA)

This form must be filled out completely. Please print.  
(Este formulario debe ser relleno completamente. Por favor escribir.)

- ☐ 1st Time Application  
(petición por primera vez)  
☐ Recertification  
(renovación)

### Part 1 – All About You (Todo sobre usted)



#### Personal Information (Información Personal)

|                                                                                                                                                                                                                                              |                                                                                                                               |                                                                                      |                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| First Name (Primer Nombre)                                                                                                                                                                                                                   | Last Name (Apellido)                                                                                                          | Birth Date (Fecha De Nacimiento)                                                     | Relationship Status (Estado Civil)                                                                                                 |
|                                                                                                                                                                                                                                              |                                                                                                                               |                                                                                      | <input type="checkbox"/> Single (soltero)<br><input type="checkbox"/> Married (casado)<br><input type="checkbox"/> Widowed (viudo) |
| Home Address (Dirección de casa)                                                                                                                                                                                                             | Apartment # (Número de apartamento)                                                                                           | City (Ciudad)                                                                        | State (Estado) Zip Code (Codigo Postal)                                                                                            |
|                                                                                                                                                                                                                                              |                                                                                                                               | <input type="checkbox"/> Brownsville<br><input type="checkbox"/> Other _____         | TX                                                                                                                                 |
| Mailing Address, if different (Dirección de correo, si es diferente)                                                                                                                                                                         | City (Ciudad)                                                                                                                 | State (Estado)                                                                       | Zip Code (Codigo Postal)                                                                                                           |
|                                                                                                                                                                                                                                              | <input type="checkbox"/> Brownsville<br><input type="checkbox"/> Other _____                                                  | TX                                                                                   |                                                                                                                                    |
| Cell Phone (Teléfono celular)                                                                                                                                                                                                                | Home Phone (Teléfono de casa)                                                                                                 | Gender (Género)                                                                      |                                                                                                                                    |
|                                                                                                                                                                                                                                              |                                                                                                                               | <input type="checkbox"/> Male (Masculino) <input type="checkbox"/> Female (Femenino) |                                                                                                                                    |
| Applicant's Email (Correo electrónico del Solicitante)                                                                                                                                                                                       |                                                                                                                               |                                                                                      |                                                                                                                                    |
|                                                                                                                                                                                                                                              |                                                                                                                               |                                                                                      |                                                                                                                                    |
| Preferred Method of Contact (Método de contacto preferido)                                                                                                                                                                                   |                                                                                                                               |                                                                                      |                                                                                                                                    |
| <input type="checkbox"/> Mail (Correo) <input type="checkbox"/> Cell Phone (Teléfono celular)<br><input type="checkbox"/> Email (Correo electrónico) <input type="checkbox"/> Home Phone (Teléfono de casa)                                  |                                                                                                                               |                                                                                      |                                                                                                                                    |
| In what language do you prefer all future communication (letters, phone calls, brochures)?<br>¿En qué idioma prefiere todas las comunicaciones futuras (cartas, llamadas telefónicas, folletos)?                                             |                                                                                                                               |                                                                                      | <input type="checkbox"/> English (inglés)<br><input type="checkbox"/> Spanish (español)                                            |
| Do you require Information in an alternate format? Please choose below.<br>¿Necesita información en un formato alternativo? Por favor, elija abajo.                                                                                          |                                                                                                                               |                                                                                      | <input type="checkbox"/> Yes (Sí) <input type="checkbox"/> No (No)                                                                 |
| <input type="checkbox"/> Braille (Braille) <input type="checkbox"/> Computer Disks (Discos de computadora)<br><input type="checkbox"/> Large Print (Letra grande) <input type="checkbox"/> Taped Audio Cassettes (Casetes de audio grabados) |                                                                                                                               |                                                                                      |                                                                                                                                    |
| How do you currently travel? (Check all that apply)<br>¿Cómo viajas actualmente? (Marque todo lo que corresponda)                                                                                                                            |                                                                                                                               |                                                                                      |                                                                                                                                    |
| <input type="checkbox"/> Drive myself (Conducir yo mismo)<br><input type="checkbox"/> Someone else drives (Alguien mas maneja)                                                                                                               | <input type="checkbox"/> Fixed Route Bus (Bus de ruta fija)<br><input type="checkbox"/> Van/Car Service (Servicio de Van/Car) | <input type="checkbox"/> Paratransit<br><input type="checkbox"/> Taxi                | <input type="checkbox"/> Walk (Caminar)<br><input type="checkbox"/> Other (Otro)                                                   |



### Disability/Medical Condition/Diagnosis Information

### (Discapacidad/Condición médica/Información de diagnóstico)

What is the disability, medical condition or diagnosis that prevents you from using BMetro Fixed Route Service? Please explain and give any information that BMetro may need to be aware about your disability?  
¿Cuál es la discapacidad, condición médica o información de diagnóstico que le impide utilizar el servicio de ruta fija de BMetro? Por favor, explique y proporcione cualquier información que BMetro pueda necesitar para conocer su discapacidad.

How does this disability prevent you from using the BMetro Fixed Route Services (regular city buses)? Please explain completely. Use a separate sheet if necessary.

¿Cómo le impide esta discapacidad utilizar los Servicios de ruta fija de BMetro (autobuses regulares de la ciudad)? Por favor explique completamente. Use una hoja separada si es necesario.

Regarding the disability (condition) mentioned above, is it temporary or permanent?

Con respecto a la discapacidad (condición) mencionada anteriormente, ¿es temporal o permanente?

☐ Temporary (Temporal)

If temporary, what date do you think your condition will be alleviated.

Si es temporal, ¿en qué fecha cree que se aliviará su condición?

☐ Permanent (Permanente)



## Mobility Aids (Ayudas de Movilidad)

**\* Please include a picture of all mobility devices checked below when returning the application. \***  
**\*(Por favor Incluya una imagen de todos los dispositivos de movilidad marcados a continuación al devolver la solicitud.)\***

Do you use any of the following mobility aids?  
¿Utiliza alguna de las siguientes ayudas de movilidad? ☐ Yes (Sí) ☐ No (No) ☐ Sometimes (A Veces)

**If you checked Yes or Sometimes, please check all mobility aids used below.**  
**Si marcó Sí o Algunas veces, marque todas las ayudas de movilidad que se usan abajo.**

|                                                                          |                                                               |
|--------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Manual Wheel Chair (Silla de ruedas manual)     | <input type="checkbox"/> Power Wheel Chair (Silla automática) |
| <input type="checkbox"/> Power Scooter (Silla automática de tres ruedas) | <input type="checkbox"/> Walking Cane (Bastón)                |
| <input type="checkbox"/> Crutches (Muletas)                              | <input type="checkbox"/> Walker (Andador)                     |
| <input type="checkbox"/> Oxygen Tank (Tanque de oxígeno)                 | <input type="checkbox"/> Other (Otro)                         |

If you use a wheel chair or scooter, please list the dimensions below in inches.  
Si utiliza una silla de ruedas o un scooter, indique las dimensiones abajo en pulgadas.

| Length (Longitud) | Width (Anchura) | Height (Altura) |
|-------------------|-----------------|-----------------|
|-------------------|-----------------|-----------------|

**IMPORTANT:** Operators will make all attempts to secure standard mobility devices. If a mobility device exceeds the normal size, the operator may ask the rider to transfer to a seat, as it may be difficult to safely secure the passenger within the mobility device. It is the rider's choice to transfer or remain in their mobility device. (As per ADA Policies and Procedures Manual)

**IMPORTANTE:** Los operadores harán todos los intentos para asegurar dispositivos de movilidad estándar. Si un dispositivo de movilidad supera el tamaño normal, el operador puede pedirle al pasajero que lo transfiera a un asiento, ya que puede ser difícil asegurar al pasajero de manera segura dentro del dispositivo de movilidad. Es la elección del usuario transferir o permanecer en su dispositivo de movilidad. (Según el Manual de Procedimientos y Políticas de la ADA)

## Traveling Assistance (Personal Care Attendants or Service Animals)

### Asistencia de viaje (asistentes de cuidado personal o animales de servicio)

|                                                                                                                                                                                                                                                       |                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Do you need to bring someone with you to help you when you travel, a personal care attendant or personal assistant?<br>¿Necesita llevar a alguien con usted para que lo ayude cuando viaje, un asistente de cuidado personal o un asistente personal? | <input type="checkbox"/> Yes (Sí)<br><input type="checkbox"/> No (No)<br><input type="checkbox"/> Sometimes (A Veces) |
| Do you need to bring a service animal?<br>¿Necesitas traer un animal de servicio?                                                                                                                                                                     | <input type="checkbox"/> Yes (Sí)<br><input type="checkbox"/> No (No)<br><input type="checkbox"/> Sometimes (A Veces) |

**\* Please note that BMetro does not provide Personal Care Attendants or Service Animals. \***  
**\* Por favor tenga en cuenta que BMetro no proporciona asistentes de cuidado personal o animales de servicio. \***

*Initial here to show you have read this notice:*  
*Inicial aquí para demostrar que ha leído este aviso: \_\_\_\_\_*



## Travel Restrictions

### Restricciones de viaje

Please answer the following questions regarding ease and length of travel.

Por favor responda las siguientes preguntas con respecto a la facilidad y duración del viaje.

|                                                                                                                                                                                           |                                   |                                  |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------|----------------------------------------------|
| Can you travel <b>outside your house/apartment</b> without the assistance of another person?<br>¿Puede viajar fuera de su casa / apartamento sin la ayuda de otra persona?                | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you travel <b>to the curb in front of your apartment</b> without the assistance of another person?<br>¿Puede viajar al bordillo frente a su apartamento sin la ayuda de otra persona? | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you travel <b>3 blocks (¼ mile)</b> without the assistance of another person?<br>¿Puedes viajar 3 cuadras (¼ milla) sin la ayuda de otra persona?                                     | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you travel <b>6 blocks (½ mile)</b> without the assistance of another person?<br>¿Puedes viajar 6 cuadras (media milla) sin la ayuda de otra persona?                                 | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you travel <b>9 blocks (¾ mile)</b> without the assistance of another person?<br>¿Puedes viajar 9 cuadras (¾ milla) sin la ayuda de otra persona?                                     | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you climb <b>three 12-inch steps</b> without assistance?<br>¿Puedes subir tres pasos de 12 pulgadas sin ayuda?                                                                        | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you wait outside without support for <b>10 minutes</b> ?<br>¿Puedes esperar afuera sin soporte por 10 minutos?                                                                        | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |
| Can you travel in <b>extreme cold/hot</b> weather?<br>¿Se puede viajar en clima frío / calor extremo?                                                                                     | <input type="checkbox"/> Yes (Sí) | <input type="checkbox"/> No (No) | <input type="checkbox"/> Sometimes (A Veces) |

## Authorization to Release Information (Autorización para divulgar información)

### Emergency Contact (Contacto de emergencia)

**In case of emergency BMetro may contact the following person.  
(En caso de emergencia, BMetro puede comunicarse con la siguiente persona.)**

Taking into consideration the severity of your disability it may be necessary for you to designate an individual with whom BMetro may maintain communication about your application. If you consider necessary to designate an individual, please complete the section below. Please keep in mind that BMetro will only provide information about your application and/or eligibility status to the individual that you have designated. You may change the designated individual(s) at any time, if you notify BMetro in writing.

Teniendo en cuenta la gravedad de su discapacidad, puede ser necesario que usted designe a una persona con quien BMetro puede mantener comunicación sobre su petición. Si considera que es necesario designar a una persona, complete la sección abajo. Tenga en cuenta que BMetro solo proporcionará información sobre su petición y / o estado de elegibilidad a la persona que haya designado. Puede cambiar la (s) persona (s) designada (s) en cualquier momento, si notifica a BMetro por escrito.

| Name (Nombre) | Relationship (Relación) | Phone (Teléfono) | Alternate Phone (Teléfono alternativo) |
|---------------|-------------------------|------------------|----------------------------------------|
|               |                         |                  |                                        |
| Name (Nombre) | Relationship (Relación) | Phone (Teléfono) | Alternate Phone (Teléfono alternativo) |
|               |                         |                  |                                        |



### Applicant's Signature (Firma del Solicitante)

I understand that the information contained in this application will be kept confidential and will be shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this application form is true and correct. In order for Brownsville Metro to evaluate my request, it may be necessary to contact a medical professional to confirm the information that I have provided.

Entiendo que la información contenida en esta petición se mantendrá confidencial y se compartirá solo con los profesionales involucrados en la evaluación de mi elegibilidad. Certifico que, a mi entender, la información en este formulario de petición es verdadera y correcta. Para que Brownsville Metro evalúe su petición, puede ser necesario contactar a un profesional médico para confirmar la información que ha proporcionado.

| Please print your name here (Applicant)<br>Por favor escriba su nombre aquí (Solicitante) | Please sign your name here (Applicant)<br>Por favor firme su nombre aquí (solicitante) | Date (Fecha) |
|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------|
|                                                                                           |                                                                                        |              |

### Applicant Helper (Ayudante del Solicitante)

If someone else other than the applicant completed this application on behalf of the applicant, that person must complete this section.

Si otra persona que no sea el solicitante completó esta petición en nombre del solicitante, esa persona debe completar esta sección.

| Name (Nombre)                                                        | Title (Titulo)             |                     |
|----------------------------------------------------------------------|----------------------------|---------------------|
|                                                                      |                            |                     |
| Agency/Relationship to Applicant (Agencia / Relación al solicitante) | Email (correo electrónico) |                     |
|                                                                      |                            |                     |
| Address (Dirección)                                                  | Phone (Teléfono)           | Fax (Número de fax) |
|                                                                      |                            |                     |





### Medical/Health Care Professional Designation

#### Designación del profesional médico / del cuidado médico

The following health care professional is familiar with my disability and is authorized to provide Brownsville Metro information in reference to my disability and to verify to BMetro all the information provided in my application for ADA Paratransit Services.

El siguiente profesional de la salud está familiarizado con mi discapacidad y está autorizado para proporcionar información del Metro de Brownsville en referencia a mi discapacidad y para verificar a BMetro toda la información proporcionada en mi petición para los Servicios de Paratransporte de ADA.

|                                                                          |                  |                            |
|--------------------------------------------------------------------------|------------------|----------------------------|
| Name (Nombre)                                                            |                  | Title (Título)             |
|                                                                          |                  |                            |
| Agency/Relationship to Applicant (Agencia / Relación con el solicitante) |                  | Email (correo electrónico) |
|                                                                          |                  |                            |
| Address (Dirección)                                                      | Phone (Teléfono) | Fax (Número de fax)        |
|                                                                          |                  |                            |

### Medical Information Release Authorization

#### (Autorización de liberación de información médica)

In order for Brownsville Metro to evaluate my request, it may be necessary to contact a medical professional to confirm the information that I have provided. My signature here authorizes Brownsville Metro to contact the doctor listed above if any additional information is needed.

Para que Brownsville Metro evalúe mi solicitud, puede ser necesario contactar a un profesional médico para confirmar la información que he proporcionado. Mi firma aquí autoriza a Brownsville Metro a ponerse en contacto con el médico mencionado anteriormente si se necesita información adicional.

|                                                                                          |                                                                                        |              |
|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------|
| Please print your name here (Aplicant)<br>Por favor escriba su nombre aquí (Solicitante) | Please sign your name here (Applicant)<br>Por favor firme su nombre aquí (solicitante) | Date (Fecha) |
|                                                                                          |                                                                                        |              |





THE NEXT SECTION NEEDS TO BE  
COMPLETED BY YOUR MEDICAL  
PROFESSIONAL ASSIGNED ON PAGE 6  
OF THIS APPLICATION. PLEASE BE SURE  
THAT **YOU** SIGN PAGE 6 GIVING  
BMETRO STAFF AUTHORIZATION TO  
CALL FOR MEDICAL RELEASE  
INFORMATION IF NEEDED. THANK YOU.

LA SECCIÓN SIGUIENTE DEBE SER  
COMPLETADA POR SU PROFESIONAL  
MÉDICO ASIGNADO EN LA PÁGINA 6  
DE ESTA SOLICITUD. ASEGÚRESE DE  
FIRMAR LA PÁGINA 6 ENTREGANDO A  
LA SOLICITUD DE INFORMACIÓN DE  
LIBERACIÓN MÉDICA DEL PERSONAL  
BMETRO SI ES NECESARIO. GRACIAS.





## Part 2 – Medical Professional (Profesional médico)

### REQUEST FOR PROFESSIONAL VERIFICATION PETICIÓN DE VERIFICACIÓN PROFESIONAL



#### Dear Medical Professional:

The applicant named in this application package is requesting ADA paratransit Services. The Brownsville Metro (BMetro) is requesting your assistance in verifying that the information provided in this application package is correct.

Please review the eligibility criteria described below and then complete the Request for Professional Verification form that is included in this package. If you have any questions, please contact the BMetro office at 956-541-4881.

The applicant named in this application package has completed the Medical Information Release Authorization (Section 8), and has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our Paratransit Services to individuals who cannot utilize available accessible fixed route services (regular bus). Please keep in mind that any condition which makes traveling to or from a boarding/disembarking location, or riding on a fixed route system more difficult or less comfortable, are not reasons for ADA Paratransit eligibility. The information you provide will allow us to make an appropriate evaluation of the request and its application to specific trips requests. Thank you for your cooperation in this matter.

#### ⚡MUST BE COMPLETED BY A PROFESSIONAL, NOT THE APPLICANT⚡

##### To the professional: Please check your professional title

- |                                                     |                                                 |                                                              |
|-----------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> physician                  | <input type="checkbox"/> physician's assistant  | <input type="checkbox"/> registered nurse/nurse practitioner |
| <input type="checkbox"/> psychiatrist               | <input type="checkbox"/> psychologist           | <input type="checkbox"/> case/resource manager               |
| <input type="checkbox"/> chiropractor               | <input type="checkbox"/> physical therapist     | <input type="checkbox"/> occupational therapist              |
| <input type="checkbox"/> certified O & M specialist | <input type="checkbox"/> licensed social worker | <input type="checkbox"/> other _____                         |

**The ADA** regulations state that persons are eligible for paratransit service if, because of a disability or medical condition, they are physically or cognitively unable to (not discomforted by or find difficult) independently use lift-equipped public transit service. ADA paratransit eligibility is not based on the person's lack of knowledge of bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for paratransit service.

**Please review the list of medical ailments below and add any additional details to the medical diagnosis,** physical or cognitive disability which causes the applicant to be unable to independently use a lift-equipped bus or light rail train some, or all of the time. Please provide specific details so we can speedily process the application for the applicant.

Name of Applicant

Date of Birth



**Diagnosis/Physical or Cognitive Disability**



- ☐ Anxiety/Depression
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chronic Obstructive/ Pulmonary Disease
- ☐ Cognitive
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Epilepsy/Seizure Disorder
- ☐ Heart Attack
- ☐ Hearing Impairment
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Intellectual Disability (IQ#) \_\_\_\_\_
- ☐ Kidney Disease/Dialysis/End Stage Renal Disease
- ☐ Lupus
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Paraplegia
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Quadriplegia
- ☐ Stroke/Cerebral Trauma (Occurrence Date): \_\_\_\_\_
- ☐ Surgery (Date): \_\_\_\_\_ Type: \_\_\_\_\_
- ☐ Thrombosis Visual Impairment
- ☐ Other: (list here)

**Regarding the disability (condition) mentioned above, is it temporary or permanent?**

- |                                                                          |                                    |
|--------------------------------------------------------------------------|------------------------------------|
| <input type="checkbox"/> Temporary                                       | <input type="checkbox"/> Permanent |
| If temporary, what date do you think their condition will be alleviated. |                                    |

**How does this condition affect the individual's ability to use BMetro fixed route service (regular bus)?**



## Mobility Aids



Does the applicant use any of the following mobility aids? ☐ Yes ☐ No ☐ Sometimes ☐ Unknown

If you checked Yes or Sometimes, please check all mobility aids used below.

|                                             |                                            |                                      |                                      |
|---------------------------------------------|--------------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Manual Wheel Chair | <input type="checkbox"/> Power Wheel Chair | <input type="checkbox"/> Crutches    | <input type="checkbox"/> Walker      |
| <input type="checkbox"/> Power Scooter      | <input type="checkbox"/> Walking Cane      | <input type="checkbox"/> Oxygen Tank | <input type="checkbox"/> Other _____ |

## Travel Restrictions

Please answer the following questions regarding ease and length of travel **without the assistance of another person**.

|                                                                                                   |                              |                             |                                    |
|---------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------------|
| Can this person travel <b>outside his/her house/apartment</b> without assistance?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person travel <b>to the curb in front of his/her house/apartment</b> without assistance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person travel <b>3 blocks (¼ mile)</b> without assistance?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person travel <b>6 blocks (½ mile)</b> without assistance?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person travel <b>9 blocks (¾ mile)</b> without assistance?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person climb <b>three 12-inch steps</b> without assistance?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person wait outside without support for <b>10 minutes</b> ?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Can this person travel in <b>extreme cold/hot</b> weather?                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |

## Visual Impairment

Does the applicant have a visual impairment of any kind? ☐ Yes ☐ No ☐ Unknown

If you checked Yes, please list any known ailments here.

|                                          |                                                           |                                               |                                              |
|------------------------------------------|-----------------------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Partially Blind | <input type="checkbox"/> Legally Blind                    | <input type="checkbox"/> Aphasia              | <input type="checkbox"/> 20/200 or worse     |
| <input type="checkbox"/> Totally Blind   | <input type="checkbox"/> Visual Field Deficit             | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> No light perception |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Wears Corrective Lenses/Contacts | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Deaf            | <input type="checkbox"/> Deaf/Blind                       | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Other _____         |

## Cognitive Disability

If this individual has a cognitive disability is her or she able to do the following?

|                                                                          |                              |                             |                                    |
|--------------------------------------------------------------------------|------------------------------|-----------------------------|------------------------------------|
| Give address and telephone numbers upon request?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Recognize a destination or landmark?                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Deal with unexpected situations or changes in routine?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Ask for, understand and follow directions?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| Safely and effectively travel through crowded and/or complex facilities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |



Brownsville, TX 78520  
Fax # 956-574-6675

Email:  
cynthia.marroquin@brownsvilletx.gov  
Website: [www.brownsvilletx.gov/599/ADA-Paratransit-Service](http://www.brownsvilletx.gov/599/ADA-Paratransit-Service)

**Medical Professional Completing Request for Professional Verification**



**I certify that the information contained in this application is true and correct.**

Name (Printed)

Office Address

Office Email

Professional License/Registration/Certification #/State

Office Phone

Office Fax

Medical Professional Signature

Date

*\*This form expires 90 days from the signature date.*

**Please return the completed application by mail or in person, to the following address:**

**Brownsville Metro  
ADA Applications  
755 International Blvd. (2nd floor)  
Brownsville, TX 78520**

**You can also email the completed application to**

**Cynthia Marroquin at  
[cynthia.marroquin@brownsvilletx.gov](mailto:cynthia.marroquin@brownsvilletx.gov)**

**Or completed application can be sent via fax to**

**(956)574-6675**

**Thank you for your continued support.**