



Dear Applicant for Metro Transit's Limited Mobility Program,

Thank you for requesting an application to apply for Metro Transit's Limited Mobility Program. The purpose of this program is to offer discounted transit fares on regular route transit service to those whose permanent or temporary disability prevents them from using public transportation with the same ease as those without a disability.

If you are currently certified for Metro Mobility i.e. door to door service, you do not need to complete the enclosed application. Our operators and/or fare inspectors accept the Metro Mobility ID Card or an "A" endorsement on your Minnesota ID Card or Drivers License.

Please be aware, the information provided in this application for reduced fare will be shared with Department of Public Safety, Driver and Vehicle Services Division, for the purpose of an evaluation of your driving ability, and that a consequence of the release of this information to Driver and Vehicle Services may be the cancellation of your driving privileges. Reevaluation will require the provision of additional medical statements addressing your ability to drive.

Once you're approved for Metro Transit's Limited Mobility Program, permanent status, you will receive a temporary identification card for use until you obtain an "L" endorsed Minnesota ID Card or Drivers License from the Department of Public Safety. (All charges and fees related to the ID must be paid by the applicant.)

If you're approved for Metro Transit's Limited Mobility Program, temporary status, you will receive a temporary identification card for use until it expires which is six months from its issuance date. Applicant's approved for temporary status must reapply every six months.

The attached application must be completed in full (front and back). Failure to complete this form in its entirety may cause denial or delay of your application. Please return completed application to:

Metro Transit - Limited Mobility Program
560 6th Avenue North, Minneapolis, MN 55411-4398

Questions regarding this application or to receive this document in alternative formats, please contact us at 612.373.3333, voice menu option #3, Monday through Friday between the hours of 7:30 a.m. and 5:30 p.m.

Regards,

Customer Relations - Metro Transit

A service of the Metropolitan Council

Metro Transit Limited Mobility Program – Medical Verification

The below must be completed by a Certified Professional Only (e.g. Licensed Physician, Nurse Practitioner, Psychologist, Social Worker, Physical Therapist or Special Education Teacher).

The applicant named on the reverse of this application requests Limited Mobility certification under eligibility guidelines found below. This program is designed to offer discounted transit fares on regular route transit service to those whose permanent or temporary disability prevents them from using public transportation with the same ease as those without a disability. To determine eligibility, medical verification is required.

Eligibility guidelines are;

- A. Use of a walker, wheelchair, scooter, crutches, leg or foot braces or other mobility aids.
- B. Missing limbs or critical parts thereof;
- C. Anatomical deformity of hand or foot;
- D. Legally blind (central visual acuity of 20/200 in the better eye with the use of corrected lenses or a visual field of less than 20 degrees or has a visual loss which prevents him/her from obtaining a driver's license;
- E. Hearing loss of 90 dbs. or greater in the 500, 1000 and 2000 Hz. ranges;
- F. Cardiovascular or respiratory condition which significantly interferes with coordination, endurance or strength;
- G. Neurological condition which significantly interferes with coordination, strength or endurance (i.e. polio, cerebral palsy, multiple sclerosis, paralysis);
- H. Muscular-skeletal condition which significantly impairs motor skills (i.e. muscular dystrophy, severe rheumatism or arthritis);
- I. Learning disability, mental or psychological impairment, if this results in a reduced capacity to perform actions necessary for use of regular route service without receiving special training;
- J. Symptoms related to dialysis treatments, epilepsy or HIV/AIDS, such that the symptoms prevent the use of public transportation with the same ease as those without these symptoms.

I certify that _____ (person's name) meets at least one of the eligibility guidelines listed above to qualify for the Limited Mobility Program.

1. Disability or condition is: Permanent Temporary (6 months or less)

2. Certified Professional Name:

Profession:

State License #

Clinic, Agency, School or Business name

Address: Street, Apt #, City, State, Zip

Daytime Phone Number:

Email Address:

Certified Professional's Signature:

Date:

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Metro Transit Limited Mobility Program Application

1. Applicants Name:

First Middle Last

Address:
Street, Apt #, City, State, Zip

Daytime Phone Number: Email Address:

2. Do you have a:

Minnesota ID Card # _____ Date of birth _____

Minnesota Driver's License # _____ Gender: M or F

Metro Mobility ID Card # _____

3. Release of Information: I AGREE THAT THE INFORMATION PROVIDED MAY BE VERIFIED WITH A MEDICAL DOCTOR OR OTHER AGENCY REPRESENTATIVE AND DO HEREBY STATE THAT THE INFORMATION CONTAINED IN THE APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I UNDERSTAND THAT INFORMATION PROVIDED IN THIS APPLICATION FOR REDUCED FARE WILL BE SHARED WITH DEPARTMENT OF PUBLIC SAFETY, DRIVER AND VEHICLE SERVICES DIVISION, FOR THE PURPOSE OF AFFIXING AN "L" DESIGNATION TO MY DRIVER'S LICENSE OR STATE ID AND THAT A CONSEQUENCE OF THE RELEASE OF THIS INFORMATION TO DRIVER AND VEHICLE SERVICES MAY BE A REEVALUATION OF MY DRIVING ABILITY AND THE CANCELLATION OF MY DRIVING PRIVILEGES.

4. Applicants now holding valid Minnesota Drivers' licenses or instructional permits are cautioned that a review of this application will be conducted by Department of Public Safety, Driver and Vehicle Services Division, and could result in:

- A reexamination of driving ability.
- Demand for license surrender if a severe disabling condition has developed since the current license was issued

5. Applicants Signature: (REQUIRED)

Name of person Preparing Form if other an Applicant:

Address: Street, Apt #, City, State, Zip

Daytime Phone Number: Email Address:

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Last Name _____

First Name _____

Temp or Perm _____