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MUSKEGON AREA TRANSIT SYSTEM
(MATS)

MATS FORM ADA-1

**APPLICATION FOR CERTIFICATION OF
ADA PARATRANSIT ELIGIBILITY**

NOTE: The information obtained in this certification process will be kept confidential to the certification process and the provision of transportation services. Information may be shared with other transit providers to facilitate your travel in those areas. The information will not be provided to any other person or agency, except those involved with this certification application.

1. Name:	2. Date:		
3. Address:			
4. Telephone (Home):	5. Telephone (Work):		
6. Birthdate:			
7. Describe physical, mental or visual condition(s) which prevent(s) you from using MATS fixed-route bus service:			
8. Is this condition temporary? Yes No	9. If yes, state the duration: Date from Date to		
10. Explain completely how this(ese) condition(s) prevent(s) you from using the fixed-route bus service:			
11. Describe any other effects of the disability of which MATS should be aware (if any):			
12. Do you use any of the following aids for mobility? (check all that apply)			
Manual Wheelchair_____	Electric Wheelchair_____		
Amigo_____	Cane_____	Crutches_____	Aide / Helper_____
Guide Dog_____	Hearing Aid_____		

<p>13. Do any of these mobility aids prevent you from using regular MATS fixed-route service? Yes No</p>
<p>14. Do you require a personal care attendant? Yes No</p>
<p>15. Describe, if any, conditions on MATS buses or routes that prevent you from using MATS regular fixed-route service:</p>
<p>16. I hereby certify that the information above is correct and I authorize the release of this form and related information to MATS only for purposes of determining eligibility.</p> <p>Signature of applicant _____</p> <p>Date _____</p>
<p>17. If someone other than applicant is completing form, please complete the following:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p>
<p>18. If it is necessary to contact a physician or other professional to evaluate your request, please provide the following:</p> <p>Name: _____ MD ___ OD ___ DO ___ PHD</p> <p>Address: _____</p> <p>Phone: _____</p>
<p>19. The physician, health-care professional, rehabilitation professional stated in block 19 is familiar with my disability and is authorized to provide any necessary information required to complete this certification:</p> <p>Signature of Applicant: _____</p>

Once you have completed this form, please print it out and sign it where indicated, or have the person helping you sign it for you. If have the ability to insert an electronic copy of your signature, you may do that, as well. Please return the form to MATS via email,US postal mail, or have someone drop the form off for you at the MATS offices.

Email: milliganmi@co.muskegon.mi.us Mail: Muskegon Area Transit System
c/o ADA Coordinator
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