PHONE: (231) 724-6420
FAX: (231) 830-1607

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 ☐

13. Do any of these mobility aids prevent you from using regular MATS fixed-route service?
Yes ☐ No ☐

14. Do you require a personal care attendant?
Yes ☐ No ☐

15. Describe, if any, conditions on MATS buses or routes that prevent you from using MATS regular fixed-route service:

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.

Signature of applicant_____

Date_____

17. If someone other than applicant is completing form, please complete the following:

Name:_____

Address:_____

Phone:_____

18. If it is necessary to contact a physician or other professional to evaluate your request, please provide the following:

Name:_____ ☐MD ☐OD ☐DO ☐PHD

Address:_____

Phone:_____

19. The physician, health-care professional, rehabilitation professional stated in block 18 is familiar with my disability and is authorized to provide any necessary information required to complete this certification:

Signature of Applicant:_____

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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Muskegon Hts, MI 49444