Rio Metro Application for Service
(people with disabilities 18 to 61 years of age)

Name: _____
First Middle Last

Home Address: _____

City_____State_____Zip_____

Apartment / Bldg Number: _____ Home Phone Number_____

Cell Phone: _____ Birth Date: _____/_____/_____

Emergency Contact Person: Name_____ Phone_____

Relationship: _____

Do you need a wheelchair lift to board the bus? _____No _____Yes

Do you use any of the following mobility aids or specialized equipment? Check all that apply:

___ Cane
___ Walker
___ Manual Wheel Chair
___ Crutches
___ Service Animal
___ White Cane
___ Power Wheel Chair
___ Power Scooter
___ Leg Braces
___ Portable Oxygen
(one bottle per oxygen dependent passenger)

Do you experience seizures? ___ No ___ Yes If yes, what type? _____

If yes, how frequent are your seizures? _____

I understand that:

- The falsification of the information may result in denial of services.
- It may be necessary to contact a professional familiar with my functional abilities to use Rio Metro.
- Rio Metro reserves the right to deny service to those passengers who fail to follow ridership policies, or who place themselves or other passengers at risk.

I certify that the information in this application is true and correct and that I have received a Rio Metro passenger manual that explains Rio Metro policies:

Applicant's Signature _____**Date**_____

Mail Application to: Rio Metro RTD
1804 Idalia Road NE
Rio Rancho, NM 87124

Revised 9 / 2015

AMERICANS WITH DISABILITIES ACT (ADA)

RIO METRO DEVIATED FIXED ROUTE PASSENGER ELIGIBILITY INFORMATION

THIS FORM IS TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL

Applicant's Name _____

Medical Diagnosis of condition causing disability (optional) _____

_____

Is the Condition Permanent? _____ Yes _____ No

If not permanent, expected duration (date) _____

The following information will be used to ensure that an accurate analysis of the applicant's trip requests can be made by the Rio Metro service.

Does applicant use any of the following aids for mobility? (Check all that apply)

____ Cane

____ Communication board

____ Service Animal

____ Power Scooter

____ Crutches

____ Personal Care Attendant

____ Picture Board

____ Power Wheelchair

____ White Cane

____ Walker

____ Portable Oxygen Supply

____ Manual Wheelchair

____ Leg Braces

____ Other type of aid

Can applicant travel without the assistance of another person? ___ yes ___ no
Can applicant climb three 9-inch steps without assistance? ___ yes ___no
Is the applicant on dialysis? ___ yes ___no
Does the applicant have a hearing impairment? ___ yes ___ no
Does the applicant have seizures or spasms? ___ yes ___ no
Is the applicant able to give address and phone number upon request? ___ yes ___no
Is applicant able to recognize a destination or landmark? ___ yes ___ no

Is the applicant able to deal with unexpected situations or unexpected changes in routine? ___ yes ___ no
Is the applicant able to ask for, understand, and follow directions? ___ yes ___ no
Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities? ___ yes ___ no

If the applicant has a visual impairment:

Visual acuity with best correction:

Right eye _____ Left eye _____ Both eyes _____

Visual fields:

Right eye _____ Left eye _____ Both eyes _____

Please describe any additional information needed to assist this rider: _____

_____

_____

Your professional area of expertise is:

____ Physician ____ Audiologist ____ Optometrist

____ Psychologist ____ Podiatrist ____ Nurse

____ Occupational Therapist ____ Physical Therapist

____ Other (please specify) _____

Your Name: _____Title: _____

Professional License # _____

Agency / Company name: _____

Office Address: _____

Office Phone Number: _____

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

Signature: _____Date: _____