

Maryland Transit Administration (MTA) Mobility Certification Office



4201 Patterson Avenue, 2nd Floor, Baltimore, MD 21215

Phone: 410-764-8181



APPLICATION FOR AMERICANS WITH DISABILITIES ACT MOBILITY PARATRANSIT SERVICE

The information that you provide will be used to determine your eligibility for MTA's Mobility service. Information will be kept confidential in accordance with state law. Everyone applying for Mobility service must complete an application and have a healthcare provider verify your disability. When you have a **complete** application signed by your health care provider, please call for an interview. We can provide transportation to your appointment. Please allow up to 4 hours for your appointment. You may be asked to participate in a functional or cognitive assessment to complete the application process.

1. **Fill out Part A** – Answer all questions, be as specific as you can. If a question does not apply to you indicate that it doesn't apply using "N/A" (not applicable). **Make sure to answer every question. Do not fill in, write on or answer any question in Part B or C, or your application may not be accepted.**
2. **Send the application to your Healthcare provider who knows the most about your disability.** See Part B for a list of professionals who can approve your application. If you have a Mental Illness that prevents you from riding public transit, you should have your mental health professional complete Part C attached to the application. **An individual may assist you with completing the application, but may not complete Part A and Parts B and C. For example, health care professionals may complete Part A for you, but the same professional may not also fill out Part B and/or C for you.**
3. **When you have a complete Part B and/or C, make sure that your healthcare provider has signed Part B and C and included his or her license number and the type of license issued.**
4. **When Part A and Part B and/or C are complete, call MTA Mobility at 410-764-8181 for an appointment.** Follow the prompt menu and select Certification. The MTA Office is open from 8:00 a.m. to 4:30 p.m., Monday – Friday, excluding State holidays.
5. Once you reach an agent, an appointment will be scheduled for you along with transportation to and from our office, if you need it.
6. The in-person interview is a required part of the application. Interviews are held at the Mobility Certification Office at 4201 Patterson Ave., 1ST Floor Baltimore, Maryland 21215.
7. **Do not mail your application. Bring your completed application with you to the interview along with government approved identification.**
8. We will not be able to interview you if you do not have a complete application. This includes Part B and/or C.
9. After your interview, you may be asked to participate in a functional or cognitive assessment. This is part of the application process. If you fail to participate in the functional or cognitive assessment, your application will be deemed incomplete.
10. Your picture will be taken at the end of the interview process. If you are deemed eligible, your picture identification will be sent to you with your determination letter. The MTA has up to 21 days to make a determination. If a determination is not made within 21 days, you may be entitled to presumptive eligibility. Call MTA for more information if you do not receive your determination letter.

PART A: APPLICANT INFORMATION (PLEASE PRINT)

Date _____

MTA Mobility Services. Please check one:

Re-certification Application Mobility ID# _____ First Application

Call-a-Ride Are you interested in Call-a-Ride service?

Yes-renewing Call-a-Ride Yes-new Call-a-Ride No-not interested in Call-a-Ride

The MTA Call-a-Ride program is a premium service that is not part of the complementary paratransit service provided by MTA pursuant to federal law. The Call-a-Ride program is a transportation option available to Mobility eligible customers. Participation in Call-a-Ride does not affect eligibility for MTA Mobility.

Last Name _____ First Name _____ MI _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Date of Birth _____ Male _____ Female _____

Email Address for correspondence (Optional): _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____ Relationship _____

Name of subdivision or apartment complex: _____

Nearest major intersecting street: _____

Nearest cross street to your residence: _____

| List the Medical Names of Your Disabilities or Medical Conditions | Is the Condition Permanent? | Duration of Condition | |
|---|-----------------------------|-----------------------|-------------|
| | | Beginning Date | Ending Date |
| | | | |
| | | | |
| | | | |
| | | | |

1. Please describe how your physical or mental condition(s) limit your ability to access bus stops or stations; ride the bus, metro/subway, light rail, or train; or transfer to another regular bus, metro/subway, light rail, or train. Please be specific.

2. Do you have a **Cognitive Disability**? (Have you ever been diagnosed with Traumatic/ Non-Traumatic Brain Injury, Developmental Disability, Borderline Intelligence, Down’s syndrome, Autism, etc.?)
Yes No If yes, please state the disability and explain how it affects you.

3. If you experience **Seizures**, please check all that apply and answer the following questions:

3a. Which type of seizures do you have?

Grand Mal Petit Mal/absence Temporal Lobe Epileptic _____

3b. When having a seizure, I: (Please check all that apply)

Am Difficult to Arouse Black Out Fall Asleep Fall Down
 Need Immediate Medical Attention Stare Blankly into Space

3c. How often do your seizures occur? _____

When was your most recent seizure? _____

3d. Are you currently taking medication to control seizures? Yes No

4. Are you currently taking prescribed medications that will, by themselves, affect your ability to ride the buses and/or trains? Yes No Please explain _____

5. Do you have a **Visual Impairment** (to include Blindness)? Yes No

If yes, please check all that apply:

- I wear contacts or glasses.
- I can recognize my stop if announcements are made.
- I am legally blind and cannot distinguish my appropriate stop, disembark, and navigate the route to my destination. I do not use a guide dog or other service animal, or any assistive device.
- I use a guide dog or other service animal, but I need paratransit to get to/from destinations that I cannot safely travel to on the route.
- I can easily hear and recognize environmental sounds that help me to determine the traffic flow patterns.
- I cannot easily hear environmental sounds that help me to determine traffic flow.
- I cannot always get out of the roadway before the traffic signal changes.
- I require a sighted guide to assist me with the following tasks: _____

6. Do you experience any of the following? Please check all that apply:

| | | | |
|-------------------------------------|--|---|--|
| Panic Attacks | | Easily Wander Off | |
| Anxiety | | Seizures | |
| Hallucinations | | Visual Impairment | |
| Delusions | | Short Term Memory Loss | |
| Paranoia | | Long Term Memory Loss | |
| Confusion | | Cannot Identify Pictures | |
| Hear Voices | | Cannot Read or Write | |
| Easily Taken Advantage of by Others | | Difficulty Understanding Written or Verbal Instructions | |

7. Do you have a **Mental/Psychological Disability**? (Do you have a current diagnosis of Bipolar Disorder, Schizophrenia, Anxiety Disorder, Paranoia, etc.?) Yes No If yes, please state the disability and explain how it affects you. **If you want Mobility to consider your Mental/Psychological Disability along with your Physical Disability and Conditions, you will need to complete Part C for Applicants with Psychiatric/Psychological Disorders.**

8. Are there any other physical or mental disabilities that affect your **FUNCTIONAL ABILITY** to ride the regular fixed route, accessible bus and transit service? (Example: difficulty with getting to the bus, waiting at the stop for the correct bus, boarding the bus, knowing when you get to your stop, and notifying the driver that you need to get off.) Yes No If yes, please explain. _____

9. Can you wait 20 minutes at a bus stop or station that **DOES NOT** have seats? Yes No If no, please explain. _____

10. Can you wait 20 minutes at a bus stop or station that **DOES** have seats and a shelter? Yes No If no, please explain. _____

11. Can you wait 20 minutes at a bus stop or station unassisted? Yes No If no, please explain. _____

12. Do you require a ramp or lift in order to board/exit the bus? Yes No

13. How far can you travel, with assistive devices and short rest breaks if needed?

Please explain any reason why you cannot travel the following distances and explain the circumstances that prevent you from traveling the specific distance.

330 feet (1 Block) _____

600-700 feet (1/8 mile) _____

1320 feet (1/4 mile) _____

2640 feet (1/2 mile) _____

14. Do you use any of the following assistive devices? Please check all that apply.

- Standard Cane Walker Braces Crutches
- Manual Wheelchair Motorized Wheelchair Scooter
- Respirator/Oxygen Service/Guide Animal Describe: _____

15. Do you require a personal care assistant (PCA) to travel with you to provide assistance?

Yes No If yes, please explain the specific assistance you require.

16. How do you travel now? Please check all that apply.

- Wheelchair/scooter Walk Drive myself
- Passenger in someone else's car Other van service
- Regular fixed route bus, metro, light rail Currently have no means of travel
- Mobility paratransit

17. Do you currently ride MTA bus or rail service? Yes No

If yes, which routes/services do you ride? _____

18. Do you feel that you could ride the accessible bus or rail with a reasonable level of effort if Mobility could get you to or from an accessible bus stop? Yes No If no, please explain.

19. Please check all that apply to you:

- I am able to board, ride, and exit a regular fixed route, accessible bus.
- When I travel on fixed route (Bus, Rail, Light Rail), I can travel alone
- I can cross the street.
- I can step on and off the sidewalk.
- I can stand on a moving bus, holding the handrail, if no seat is available.
- I can use a telephone to get bus schedule information.
- I can find my way to the bus stop after being shown where it is based.
- I can transfer to another bus or train after being shown where it is based.
- I can hear and understand the automatic announcement system on the bus.
- I need assistance understanding and navigating the fixed route system.

20. Is there anything else you wish to tell us about your ability to travel outside your home?

I hereby certify, under the penalties of perjury, that the information submitted is true and correct. I understand that providing any false information on this application may constitute a crime punishable under the law. I certify that I have not completed or answered questions in Part B or C of this application. I understand that the MTA will rely upon this information in making a determination as to my eligibility for participation in this program.

I understand that I am required to participate in an in-person interview as part of this application, and that I may also be required to participate in a functional assessment. I understand that I may not record any part of the application process without advanced written consent from the MTA.

I further authorize the release of any personal or medical information to appropriate parties that is necessary in the determination of my eligibility for Mobility / Paratransit Services.

Applicant Signature: _____ **Date:** _____

If a person other than the applicant has completed this form, please check one:

I certify that the information provided in this application is true and correct based upon the **information given to me by the applicant**. I helped fill out the form.

I certify that the information provided in this application is true and correct based upon **my own knowledge** of the applicant's health condition or disability.

Print Name: _____

Signature: _____

Relationship to Applicant: _____

Telephone: _____ (day) _____ (evening)

Maryland Transit Administration (MTA) Mobility Certification Office



4201 Patterson Avenue, 2nd Floor, Baltimore, MD 21215

Phone: 410-764-8181



PART B: LICENSED PROFESSIONAL VERIFICATION

Dear Licensed/Certified Professional:

The Americans with Disabilities Act requires transit systems that operate fixed route service to offer complementary paratransit to people with disabilities who cannot use the regular MTA service. In accordance with the Act, the MTA offers a door-to-door bus service for those who cannot use the regular fixed-route buses and transit services.

To qualify for specialized MTA Mobility service, applicants must have a history of an impairment that substantially limits their ability to independently access, board, or ride fixed route services. A disability must prevent travel not merely make it more difficult to get to the bus stop or train station, get on the vehicle, and ride independently.

MTA bases eligibility determinations on the information provided by the applicant. MTA also considers the information provided by the healthcare professional most able to describe the most limiting conditions of the applicant. Some applicants may be assessed by an Occupation Therapist as well.

Passengers must be certified eligible in order to use the Mobility bus service. Applicants may be found eligible for this Mobility service for some or all of their trips. Be aware that all MTA fixed route and rail services are lift or ramp equipped, have wheelchair securement areas and priority seating, and provide audio route and stop announcements.

In responding to the following questions, please focus on the applicant's functional abilities.

The information you provide, along with the applicant's information, will enable us to make an appropriate determination. All information will be kept confidential.

If you have assisted an applicant complete Part A, you cannot also verify Part B. Persons completing Part B must be licensed or certified in one of the following specialties:

Vocational Rehabilitation Counselor
 Orientation and Mobility Instructor
 Respiratory Therapist
 Occupational or Physical Therapist
 Audiologist
 Independent Living Specialist
 Speech and Language Pathologist

Physician
 Physician's Assistant
 Nurse Practitioner
 Psychiatrist/ Psychiatric Social Worker
 Ophthalmologist
 Optometrist
 Psychologist

Part B: Professional Verification

We require that all questions be clearly and accurately completed. If you change an answer, please initial the change. Failure to do so may delay the applicant’s determination. Please make certain that responses are legible.

Applicant Name: _____

Please indicate the nature and ICD code of your patient’s condition or disability. This list is not all inclusive. Please add if needed. Place the ICD Code in the blank to the left of the condition listed and specify the condition in the space provided to the right. If the applicant is taking medications that would impair his/her mobility, please include this information.

| ICD CODE | Condition | Reason the Diagnosis Limits the Ability to Use Fixed Route Buses or Trains | | Clinical Diagnosis | Client Report | Temporary |
|----------|-------------------------|---|-------------|--------------------|---------------|-----------|
| | | | | Check | Check | Duration |
| | DIABETES | | | | | |
| | END STAGE RENAL DISEASE | | | | | |
| | CANCER TREATMENT | | | | | |
| | AMPUTATION | Extremity: | Prosthesis: | | | |
| | NEUROLOGICAL CONDITION | | | | | |
| | NEUROMUSCULAR CONDITION | | | | | |
| | PULMONARY DISEASE | Oxygen use <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | | Inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | CARDIAC DISEASE | Has mild to moderate exercise been recommended <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | | | | | | |
| | TRAUMATIC BRAIN INJURY | | | | | |
| | ALZHEIMER’S | | | | | |
| | DEMENTIA | | | | | |

| ICD CODE | Condition | Reason the Diagnosis Limits the Ability to Use Fixed Route Buses or Trains | | Clinical Diagnosis | Client Report | Temporary |
|----------|--------------------|--|---------------------|--------------------|---------------|-----------|
| | | | | Check | Check | Duration |
| | AUTISM | | | | | |
| | COGNITIVE DEFICITS | | | | | |
| | VISUAL IMPAIRMENT | Corrected Vision: | Type of Impairment: | | | |
| | | | | | | |

___ ARTHRITIS ___ Mild ___ Moderate ___ Severe ___ Disabling
 Location And Type _____

___ HEARING IMPAIRMENT ___ Mild ___ Moderate ___ Severe
 Requires interpreter _____

___ SEIZURE DISORDER
 ___ Absence Seizures ___ Petit Mal ___ Grand Mal ___ Complex Parital ___ Simple Partial
 ___ Psychomotor ___ Tonic Clonic Seizures controlled by medications? Yes No
 If no, please explain: _____

Is the client able to drive? Yes No

What would be the duration of this/these conditions? _____

- Does the client require a mobility device? Yes No
- If so, what type? _____
- Does the applicant have any other conditions not listed above that would impact the ability to travel on fixed route transit.

Please check the appropriate box and provide explanation.

- Can your client independently stand for 10-20 minutes at a bus stop without a bench? Yes No

- Can your client independently cross a busy intersection? Yes No

- Can your client independently negotiate curbs or curb cuts safely? Yes No

- Can your client independently negotiate areas without sidewalks? Yes No

- Can your client independently negotiate hills or uneven terrain? Yes No

- Can your client independently visually locate a bus stop? Yes No

- Can your client independently go up and down three 10" steps using a handrail? Yes No

- Can your client independently get on and off conventional low floor buses with no steps?
 Yes No

- Can your client independently get on and off a bus with passenger lift or ramp? Yes No

- Can your client independently ride conventional bus if driver assigns priority seating Yes No

- Can your client independently recognize destination and be able to signal driver? Yes No

- Can your client independently inform driver they are being dropped off at the wrong stop?
 Yes No

- Can your client independently get help if dropped of at wrong destination? Yes No

Please check most appropriate box which best describes your client

| | Little or no Discomfort | Moderate Discomfort | Severe Discomfort | Medical Condition Affecting Comfort Level | Observation | Client Report |
|-----------------------|-------------------------|---------------------|-------------------|---|-------------|---------------|
| HEAT | | | | | | |
| COLD | | | | | | |
| HUMIDITY | | | | | | |
| NIGHT | | | | | | |
| RAIN | | | | | | |
| AIR QUALITY | | | | | | |
| CROWDS | | | | | | |
| NOISE | | | | | | |
| UNEXPECTED SITUATIONS | | | | | | |
| UNFAMILIAR LOCATION | | | | | | |

13. How far can the applicant travel, including any assistive devices and short rest breaks if needed? **Please explain the basis for your conclusion and note if each distance has been observed or client reported.**

330 feet (1 Block) _____

600-700 feet (1/8 mile) _____

1320 feet (1/4 mile) _____

2640 feet (1/2 mile) _____

Applicant Name:

Please Print Name and Title of Health Care Professional

Full Name & Title: _____

Clinic/Business: _____

Street Address: _____

City/ State/ Zip Code: _____

Telephone# & Fax#: _____

E-mail(optional): _____

Professional License, Registration or Certification Number: _____

Agency Issuing License/Certification: _____

I have reviewed all of the information contained in this application and hereby certify that all the information is true and correct to the best of my knowledge and ability. I certify that the applicant named herein, is under my professional care. I hereby swear and affirm that the applicant has the conditions indicated and that the applicant has not had any participation in completing Part B of this form.

Signature: _____

Date: _____

Applicants must present the original form in person by scheduling an interview. Please do not mail or fax this application – we will not accept it and it will delay a determination.

For more information about Mobility, call 410-764-8181 or Maryland Relay Service at 711.
This application is available in alternate formats (Large Print) upon request.

Maryland Transit Administration (MTA) Mobility Certification Office



4201 Patterson Avenue, 2nd Floor, Baltimore, MD 21215

Phone: 410-764-8181



PART C:

PROFESSIONAL VERIFICATION FOR PSYCHIATRIC AND PSYCHOLOGICAL DISORDERS

Dear Licensed Professional:

The Americans with Disabilities Act requires transit systems that operate fixed route service to offer complementary paratransit service to people with disabilities who cannot use the regular MTA transit service. In accordance with the Act, the MTA offers a door-to-door bus service for those who cannot use the regular fixed route for all or some of their trips.

To qualify for specialized MTA Mobility service, applicants must have a history of an impairment that substantially limits their ability to independently access, board, or ride other MTA service. A disability must prevent travel not merely make it more difficult to get to the bus or train stop, get on the vehicle, and ride independently.

MTA bases eligibility determinations on the information provided by the applicant. MTA also considers the information provided by the healthcare professional most able to describe the most limiting conditions of the applicant. Some applicants may be tested by our Occupational Therapist as well.

In responding to the following questions, please focus on the applicant's cognitive / functional abilities. The information you provide, along with the applicant's information will enable us to make an appropriate determination. All information is kept confidential.

If you have assisted an applicant complete Part A, you cannot also verify Part C. **Persons completing Part C -- Psychiatric/Psychological Disorders must be licensed or certified in one of the following specialties: Psychiatry, Psychologist or Psychiatric Social Work.**

We require that all questions be clearly and accurately completed. Applicants must return this original document, no copies. Failure to do so will delay a determination and access to Mobility service.

Part C: Professional Verification to be completed only by Psychiatrist, Psychologist or Psychiatric Social Worker.

We require that all questions be clearly and accurately completed. If you change an answer, please initial the change. Failure to do so may delay applicants determination. Please make certain that responses are legible.

Applicant Name:

Date of Last Contact with Patient: _____

1. In what capacity do you know the applicant? _____

2. How long have you known or worked with the applicant? _____

3. When did you last see or treat the applicant? _____

Please provide more detailed information about the stated disability and the extent of the disability.

4. What is the formal diagnosis of the applicant's disability (DSM-IV or other)? _____

5. What was the date of onset? _____

6. What is the prognosis? _____

7. Is the applicant taking any psychotropic, antidepressant or other Medication(s) prescribed by you?

Yes No If yes, please list the type, frequency, dose and any comments about how the

medication(s) may complicate the individual's independent mobility in the community.

| Medication Type | Dosage | Effect on Functional Ability (if any) |
|-----------------|--------|---------------------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Applicant Name:

9. If the applicant takes their medication compliantly, will they be able to travel independently in the community? Yes No N/A

Comments: _____

10. Do you deem the applicant to be compliant in taking prescribed Medication? Yes No N/A

Comments: _____

11. Is there anything about the use of medication that would complicate the applicant's use of public transportation? Yes No N/A If Yes, explain: _____

12. Has the applicant's functional ability decreased temporarily due to adjustment to medication? Yes No N/A If Yes, please explain, and note the expected duration of the decrease in

functional ability. _____

13. Does the applicant currently experience either auditory or visual hallucinations?

Yes No N/A Comments: _____

14. If Yes, would they be likely to experience auditory or visual misperceptions due to hallucinations?

Yes No N/A Comments: _____

Applicant Name: _____

15. Are any of the following skills affected by the applicant’s disability? If Yes, please explain, describing the effect and the extent of limitation caused by the disability. Is the applicant able to:

| Activity | Yes | No | Some-times | Comments |
|---------------------------------|-----|----|------------|----------|
| Travel alone outside the home | | | | |
| Leave the house on time | | | | |
| Seek and act on directions | | | | |
| Find way to/from bus stop | | | | |
| Cross Streets | | | | |
| Wait for a bus | | | | |
| Board the correct bus | | | | |
| Ride the bus | | | | |
| Exit at the correct destination | | | | |
| Transfer to a second bus | | | | |
| Monitor time | | | | |
| Deal with unexpected situations | | | | |

Comments: _____

16. Are any of the following affected by their disability? If yes, please explain.

| Activity | Yes | No | Some-times | Comments |
|-------------------------------------|-----|----|------------|----------|
| Judgment | | | | |
| Problem Solving | | | | |
| Insight (Recognizing a problem) | | | | |
| Coping Skills | | | | |
| Short-Term Memory | | | | |
| Long-Term Memory | | | | |
| Concentration | | | | |
| Orientation | | | | |
| Communication | | | | |
| Attention to task (distractibility) | | | | |

Comments: _____

Applicant Name:

17. Would training, driver assistance, or tools such as ID cards, printed route directions, etc., help to minimize the effects as noted?

Yes No N/A Comments: _____

18. Is the goal of traveling independently (even limited travel in the neighborhood) within the context of treatment? Yes No N/A Comments: _____

19. Would the use of alternative transportation (ADA paratransit service) conflict with the goals of therapy, such as confidence building? Yes No N/A
Comments: _____

20. Would alternative transportation interfere with the applicant's therapy or improvement? Yes No N/A Comments: _____

21. Does the applicant demonstrate inappropriate social behavior (for example, are they aggressive or overly friendly)? If Yes, please describe.

Yes No N/A Comments: _____

22. Comments regarding current travel and activities:

23. Does the individual drive a car? Yes No

24. Are there any other life skills that the individual lacks that would be an indication of their inability to travel on a fixed route bus or train? Yes No If Yes, please describe. _____

Applicant Name: _____

25. Is there any additional information regarding this individual’s functional ability to use regular fixed route bus or train service, or any special circumstances that you believe should be considered _____

Please Print Name and Title of Health Care Professional

Full Name & Title: _____

Clinic/Business: _____

Street Address: _____

City/ State/ Zip Code: _____

Telephone# & Fax#: _____

E-mail(optional): _____

Professional License, Registration or Certification Number: _____

Agency Issuing License/Certification: _____

I have reviewed all of the information contained in this application and hereby certify that all the information is true and correct to the best of my knowledge and ability. I certify that the applicant named herein, is under my professional care. I hereby swear and affirm that the applicant has the conditions indicated and that the applicant has not had any participation in completing Part C of this form.

Signature: _____

Date: _____

Applicants must present the original form in person by scheduling an interview. Please do not mail or fax this application – we will not accept it and it will delay a determination.

For more information about Mobility, call 410-764-8181 or Maryland Relay Service at 711.
This application is available in alternate formats (Large Print) upon request.

Applicants who do not qualify for Mobility / Paratransit service may be eligible for MTA Reduced Fare status on regular fixed-route services (Local Bus, Metro Subway, Light Rail).
Please call 410-767-3441 for more information on the Reduced Fare program.

Dear Applicant:

If you would like to apply for the first time or recertify for MTA Mobility service, you must complete the following steps:

1. **Call Mobility at 410-764-8181 for an application or go to <http://mta.maryland.gov/mobility> website and download a copy of the application.** Do not download applications from any other site since it may not be the most current application form.
2. Read and follow the directions in the application. Complete Part A of the Application and have one of the health care professionals listed on the application complete Part B.
If **Mental Illness** is your **primary reason (most limiting condition)** for applying for Mobility you will want to have the appropriate health care professional complete Part C. If you have any questions please call Certification at 410-764-8181 and select Option 6.
3. **Call 410-764-8181 and select Option 6 to schedule to an appointment when Part A, Part B and Part C (if applicable) are complete.** We will confirm your name, address, date of birth, phone number, mobility aids, and if you require information to be sent in an alternative format. We can provide free transportation to and from the in-person interview at 4201 Patterson Avenue, Baltimore, MD, 21215.
4. **On the day of your appointment for an in-person interview, bring the following items:**
 - A **government issued ID card** (such as a driver's license, social security card, Military ID, etc.) is required to enter the building.
 - Mobility Application **Part A: Applicant Information and all Professional Verifications (Part B and/or C) that you wish to submit.** Bring the originally completed and signed documents. We will not accept copies or documents that have been altered. If you cannot provide these documents, you will not be interviewed and it will delay your eligibility determination.
 - **Mobility ID card** if you are a current customer.

On the day of the interview, please allow up to 4 hours for your appointment. You may also be asked to participate in a functional assessment, which may take about an hour. You will not receive your determination on the day of the interview.

MTA has up to 21 days to make a determination. If a determination has not been made within 21 days, please call Mobility Certification Option 6 to discuss your right to presumptive eligibility until a decision on your eligibility can be made.

If it is determined you are not eligible or conditionally eligible for Mobility service, the determination letter will provide you with the details on how to appeal the decision. You have 60 days to appeal a determination.

You can obtain information about the appeal process or other information about Mobility service by exploring our website at (<http://mta.maryland.gov/mobility>).

V.5.28.2015

Call-a-Ride is a separate program available to certified Mobility users. You will need to complete the Call-a-Ride paperwork during the interview. Be advised that there is a 4-week waiting period for receipt of a new/renewed Call-a-Ride Card. There are no extensions granted for an expired card. If you are recertifying, please do so as soon as possible to prevent a lapse in services.

Sincerely,

MTA Mobility / Call-a-Ride Certification Office