5081 Fred Wilson • El Paso, TX 79906
Office 212-0100

Applicant's Name	**Applicant's Date of Birth**

Dear Doctor/Agency Personnel:

Sun Metro LIFT provides door-to-door transportation service on a share-ride basis using small buses equipped with hydraulic wheelchair lifts. This service is available to persons who because of their disability, are prevented from:

- Independently getting to/from a bus stop or transfer point using the traditional Sun Metro fixed-route bus system.
- Independently boarding, riding/exiting a Sun Metro fixed-route bus.
- Boarding or getting to/from a bus stop because of the inability of the bus to deploy the lift or ramp at an inaccessible bus stop.

The above applicant is applying for Sun Metro LIFT services and is kindly requesting information regarding their disability. This information will allow Sun Metro LIFT to properly evaluate the applicant's inability to ride Sun Metro's mainstream fixed-route system and thereby becoming eligible for Sun Metro's paratransit system.

Thank you for your cooperation.

Please print and refrain from using medical codes

1. Capacity in which you know the applicant: _____
2. Condition causing the disability: _____
3. Is the condition temporary?

   ☐ Yes ☐ No

   If yes, what is the expected duration: _____
4. If the person has a disability affecting mobility, is the person able to travel without assistance?

   Yes ☐ No ☐ Sometimes

   If you indicated 'no' or 'sometimes', please explain:

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5. Is the applicant able to travel up to ¼ of a mile without assistance or equivalent to 4 blocks?

   ☐ Yes ☐ No

6. Is the applicant able to wait outside for 10 – minutes without assistance or support?
   ☐ Yes ☐ No

7. Does the applicant utilize any mobility aids?
   Please mark all that apply:
   ☐ Portable Oxygen ☐ Crutches ☐ Walker
   ☐ White Cane ☐ Service Animal ☐ Leg Braces
   ☐ Powered Wheelchair ☐ Powered Scooter ☐ Prosthesis
   ☐ Manual Wheelchair ☐ Walking Cane ☐ Communication Board
   ☐ Respirator ☐ Other, please explain:
   _____

8. Does the applicant have a visual impairment? (e.g., Peripheral vison, Macular Degeneration, Cataracts, etc.)

   ☐ Yes ☐ No

   a. If yes, please complete the applicant's visual acuity:
   Right eye _____ Left eye _____ Both eyes _____

   b. If other visual conditions, please describe: _____

9. If the applicant has a visual impairment, is the applicant able to travel after dark independently?
   Yes ☐ No ☐ Sometimes

   If you indicated 'no' or 'sometimes', please explain:

10. Does the applicant have a hearing impairment?
    Yes ☐ No

    If yes, please explain condition:

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11. Does the applicant have a cognitive impairment?

    Yes ☐ No

    If you indicated 'yes' please explain condition:

12. If the applicant has a cognitive impairment, can the applicant provide general information upon request? (i.e., telephone number, address, name)

    ☐ Yes ☐ No ☐ Sometimes

    If you indicated 'no' or 'sometimes,' please explain:

13. Can the applicant deal with unexpected situations in daily routine?

    ☐ Yes ☐ No ☐ Sometimes

    If you indicated 'no' or 'sometimes', please explain:

14. Can the applicant ask for, understand, and follow directions?

    ☐ Yes ☐ No ☐ Sometimes

    If you indicated 'no' or 'sometimes', please explain:

15. Can the applicant safely and effectively travel in a crowded area?

    ☐ Yes ☐ No ☐ Sometimes

    If you indicated 'no' or 'sometimes', please explain:

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16. Does the applicant take any medications?

☐ Yes ☐ No

17. If yes, does the medication cause any side effects that would impact the applicant's functional ability?

Yes ☐ No ☐ Sometimes

If you indicated 'no' or 'sometimes', please explain:

19. Are there any other conditions or disabilities that would prevent this applicant from riding the tradition fixed-route system that Sun Metro should be aware of?

20. Should we have further questions regarding the applicant most limiting functional ability, do you authorize Sun Metro LIFT reach out to you for further questions?

☐ Yes ☐ No

Important: Sun Metro LIFT will only use this information to determine the applicant's eligibility to use Sun Metro LIFT. Sun Metro LIFT will keep this information confidential and secure and will only use it for transportation-related purposes.

I certify that the information provided is true and correct to the best of my knowledge.

Agency Personnel or Physician's Name: _____

Address: _____ Suite: _____

Phone Number: _____

Signature: _____ Date: _____