MARS Application Instructions

Thank you for inquiring about eligibility for Madison Assisted Ride System. Enclosed is a copy of our MARS application. Also enclosed is a brochure that explains what MARS is and who is eligible for these services. **Please read these instructions and the enclosed brochure carefully before completing the application form**.

MARS Eligibility Requirements

According to the Americans with Disabilities Act (ADA), a disabled individual is one who has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual". The MARS service was created with the sole purpose of providing transportation services to individuals living within Madison's City limits who are considered to be "disabled" under ADA guidelines. To be eligible to use the MARS service, an individual must have an impairment that clearly prevents or limits his or her ability to operate a motor vehicle.

How do I Apply?

The enclosed forms must be filled out **completely** and returned to the address provided below. **Incomplete forms will be returned to applicant for completion.** The first form is for you or your caregiver to complete in order to provide us with the information we need to evaluate your application. The second form should be completed by your physician or other licensed professional health care provider who is able to verify the information on your application and provide any additional information about how your disability prevents you from using traditional methods of transportation. Before taking the form to your physician, you should complete and sign the Authorization to Release Medical Information at the top of that form. Once all information on the form is completed, you may mail or fax both forms to:

City of Madison
Department of Recreation
8324 Old Madison Pike
Madison, AL 35758
Fax: (256) 772-9377

If you have questions, please call (256) 772-2551, or (256) 772-9300

Note: Due to the limited number of vehicles used for the MARS Program, transportation is limited to inside the following boundries.

South: We do not go further than Golf Road
North: We do not cross Sparkman Drive
East: We do not go past Whitesburg Drive
West: We do not go further than County Line Road, except to pick-up residents within the Madison City Limits.

For office use only:
Date Received: ___/___/___
Received By:_____
Approved: _____
Denied: _____

CITY OF MADISON
MARS APPLICATION

We are requesting this information in order for MARS to serve you. This information will not be provided to any other person or agency except those you list on this application.

Incomplete forms will be sent back to you. This will slow down the certification process.

GENERAL INFORMATION (PLEASE PRINT OR TYPE)

Last Name: _____ First Name: _____M/I_____

Address:_____ Apt. #:_____

City: _____ State: _____ ZIP: _____ Sex: M____ F____

Telephone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Date of Birth: _____/_____/_____ E-Mail Address: _____

Address where MARS will pick you up, if different from above:

_____

Emergency Contact:

Name: _____ Relationship: _____

Telephone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Did someone assist you in filling out this form? Yes: _____ No: _____

Should this person be contacted if additional information is needed? Yes: ____ No: ____

If 'No' was checked in the above question, please list an individual allowed to provide additional information:

Name: _____ Relationship: _____

Telephone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

Address:_____ Apt. #:_____

City: _____ State: _____ ZIP: _____

INFORMATION ABOUT YOUR FUNCTIONAL ABILITIES

1. Do you currently travel with a personal care attendant or escort?

   ____ Yes ____ No

2. If you travel with the assistance of an escort, what type of assistance do they provide?

   ____ Mobility ____ Medication

   ____ Transfers ____ Other: _____

3. Do you use any of the following mobility aids or specialized equipment?

   ____ I do not use any mobility aids. ____ Cane ____ White Cane

   ____ Motorized Wheelchair ____ Walker ____ Scooter

   ____ Manual Wheelchair ____ Leg Braces ____ Crutches

   ____ Respirator/Portable Oxygen Tank ____ Service Animal ____ Other_____

Please Note: A wheelchair or other mobility device must meet the definition of a "common wheelchair" as specified in the ADA regulations: i.e., not more than 30" wide and 48" long when measured 2" from the floor and must weigh less than 600 lbs when occupied.

4. Using a mobility aid on your own, how far can you travel?

   ____ I cannot travel outside my home or apartment

   ____ I can get to the curb in front of my home or apartment

   ____ I can travel up to 200 feet

   ____ I can travel up to ¼ mile

   ____ I can travel over ¼ mile

5. How do you currently travel? (Check all that apply)

   ____Drive myself ____Someone else drives me

   ____Taxi Other:_____

6. According to the Americans with Disabilities Act (ADA), a disabled individual is one who has a “physical or mental impairment that substantially limits one or more of the major life activities of such individual”. The MARS service was created with the sole purpose of providing transportation services to individuals living within Madison’s City limits who are considered to be “disabled” under ADA guidelines. To be eligible to use the MARS service, an individual must have an impairment that clearly prevents or limits his or her ability to operate a motor vehicle.

   Do you have an impairment that clearly prevents you from operating a motor vehicle?

   ____Yes ____No

7. Can you maintain balance while seated on a moving vehicle?

   ____Yes ____No

8. Can you independently get on and off of a lift-equipped bus or climb three (3) 10” steps?

   ____Yes ____No

9. Can you find a seat by yourself without assistance of another person?

   ____Yes ____No

10. List your 5 most frequent destinations and how you currently get there:

Doctor/Destination Name	**Address**	**Phone #**	**Reason- Work or Doctor**	**How do you currently get there?**

For Applicants with Vision Disabilities

If Not Applicable, Please check here ☐

1. Cause of vision loss/ diagnosis _____

2. Are you totally blind? Yes _____ No _____

3. My vision is worse during these conditions:

   ____Bright Sunlight

   ____Nighttime

   ____Dimly lit or shaded places

   ____About the same in all lighting

4. My eye condition is considered to be:

   _____Stable

   _____ Degenerative

   _____ Other (please explain) _____

5. Most often, I use the following mobility aids when I walk outdoors:

   ____Sighted (person) guide

   ____Dog guide

   ____Long white cane

   ____Optical devices (telescope, light, special glasses, etc.)

   ____None of the above

   ____ Other (please list)

CERTIFICATION OF APPLICATION

I hereby certify that, to the best of my knowledge, information given in this application is correct. I understand that the application will be returned if it is not completed. I further understand that the results of this review will be based on ADA definitions and guidelines and may require additional information from me, such as additional consultation from my physician or other professional. I understand that failure to adhere to the policies and procedures for using MARS may be grounds for suspension or revoking my eligibility to participate in this program.

Applicant's Signature: _____ Date: ____/____/____

Please review each of your answers to make sure that you have completed all of the questions to the best of your ability.

Thank you.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(TO BE COMPLETED BY APPLICANT)

I hereby authorize the following licensed professional who can verify my disability or health related condition to release information to the City of Madison Recreation Department. The information will be used only to verify my eligibility for transportation services. I understand that I have a right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:_____

_____

Address:_____

City: _____ State: _____

Zip Code: _____ Phone:_____

Applicants Signature: _____ Date: _____

_____

Instructions for Medical Verification Form
To be completed by Doctor or Healthcare Professional

It is important to determine if the above applicant is applying for the Madison Assisted Ride Program because their disability or health conditions completely prevent conventional travel some or all of the time. The MARS program was NOT developed to be used as a 'convenient' travel option, but rather, a service to individuals who are truly in need.

The above named applicant has indicated that you can provide information regarding his or her disability and its impact upon his or her ability to utilize our transit services. The MARS program will provide services to eligible persons whose disability prevents them from utilizing other methods of transportation. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation in this matter.

The term "disabled" for our purposes is defined as: Any person who by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability is unable, without special facilities to travel as effectively as persons who are not so affected.

Capacity in which you know the applicant: _____

_____

Medical diagnosis of condition causing disability **(in layman's terms please)**: _____

_____

_____

Date of onset: ____/____/____ Is the condition temporary? _____Yes _____ No

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

When did you last see the applicant? _____

Expected duration (with specific date if applicable): _____

IF THE PERSON HAS A DISABILITY AFFECTING MOBILITY, IS THE PERSON…

Able to walk 200 feet without assistance? _____ Yes _____No

Able to climb three 10-inch steps without assistance? _____Yes _____No

If sometimes, explain: _____

Able to wait outside without support for 10 minutes? _____Yes _____No
If sometimes, explain: _____

Does this individual require an escort for transportation? _____Yes _____No

Does this person use any mobility aids? If so, what? _____

IF THE PERSON HAS A VISUAL IMPAIRMENT…

Visual acuity with best correction:

Right Eye _____ Left Eye _____ Both Eyes _____

Visual fields:

Right Eye _____ Left Eye _____ Both Eyes _____

IF THE PERSON HAS A COGNITIVE DISABILITY: IS THE PERSON ABLE TO?

Give addresses and telephone numbers upon request? _____Yes _____No

Recognize a destination or landmark? _____Yes _____No

Deal with unexpected situations or unexpected changes in routine? _____Yes _____No

Ask for, understand, and follow directions? _____Yes _____No

Safely and effectively travel through crowded and/or complex facilities? _____Yes ____No

Are there any other effects of the applicant's disability which the City of Madison should be aware? Please describe.

_____

_____

Your name and title: _____

Organization Name & Address: _____

Office phone number: (_____) _____

The information on this application is true and correct to the best of my knowledge.

Signature: _____ Date: _____