Enhanced Mobility for Seniors and Persons with Disabilities
5310 Program
Eligibility Determination

Please have your doctor or a certified agency complete and sign this form.

Applicant's Name: _____

Applicant's Date of Birth: _____

Dear Doctor/Agency:

Amistad provides curb-to-curb transportation service on a shared-ride system using vehicles equipped with hydraulic wheelchair lifts. This service is available to seniors and persons with disabilities who are unable to:

- **Independently travel to/from a bus stop using traditional fixed-route buses**
- **Independently board, ride and exit a public transportation fixed-route bus**
- **Board or travel 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 the 5310 Transportation Program—Enhanced Mobility for Seniors and Persons with Disabilities and is kindly requesting information regarding his/her disability. This information will allow Amistad to properly evaluation the applicant's inability to ride the El Paso City/County transit traditional fixed-route system and thereby becoming eligible for Amistad paratransit system. *Thank you for your cooperation.*

Eligibility Determination form must be filled out completely to be approved.

1. Capacity in which you know the applicant: _____
2. Condition causing the disability: _____
3. Is the condition temporary? Yes ☐ No ☐
   a. 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 ☐ explain: _____
   _____
   _____
5. Does the person use any mobility aids? Yes ☐ No ☐
   a. If yes, describe: _____
      _____

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6. Does the applicant have a visual impairment? Yes ☐ No ☐
   (e.g., peripheral vision, macular degeneration, cataracts, etc.)
   Right eye _____ Left eye _____ Both eyes _____
   If other vision condition, please describe: _____
   _____

7. **Does the applicant have an intellectual disability? Yes ☐ No ☐**
   If yes, please describe: _____
   _____
   _____

8. **Are there any other conditions or disabilities that would prevent this applicant from riding the traditional wheelchair-accessible fixed route that Amistad should be aware of?**_____
   _____
   _____
   _____
   _____

I certify that the information provided is true and correct to the best of my knowledge.
Agency or Physician's Name: _____
Address: _____
Phone Number: _____
Signature: _____Date: _____
Print Name: _____