



NEW FREEDOM PROGRAM

The Detroit Department of Transportation (DDOT) New Freedom Program is a federally funded grant service for Detroit, Highland Park, and Hamtramck residents designed to transport disabled individuals to jobs, higher education, training, medical appointments and other related non-emergency trips. **The New Freedom program provides service up to 25 miles in Wayne, Oakland and Macomb Counties. The fare is \$2.50 per one way trip.**

Administration Hours: 8:00am to 4:00pm Monday – Friday

Operations Hours: 5:00am to 7:00pm Monday – Saturday

What are the eligibility guidelines for New Freedom?

New Freedom was created to provide origin to destination, shared ride paratransit services for individuals with a disability that prevents them utilizing the fixed route bus system. A person who is unable to independently board, ride, and/or disembark from a ramp-equipped bus or a person who is unable to navigate the large fixed route bus system without assistance of another person may be eligible for the New Freedom program.

How do you apply for the New Freedom Program?

Applicants must complete the attached application and have the professional verification form filled out by a licensed professional familiar with the applicant's functional limitations. The application processing time is 21 business days excluding the date the application was received. Once reviewed and approved, an eligible New Freedom rider will be certified and assigned a New Freedom Registration I.D. number that will allow the rider to schedule New Freedom trips. **Applicants may mail the attached application and professional verification form along with a valid copy of their Michigan identification to:**

**Special Fares Division
100 Mack Ave
Detroit, MI 48201
Office number: (313) 208-7363 Option 3**

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NEW FREEDOM APPLICATION
(PLEASE PRINT CLEARLY)

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apartment/Unit #: _____

City: _____ Zip Code: _____ Date of Birth: _____

Phone: _____ Alternative#: _____ Email: _____

What is the functional limitation that qualifies you for New Freedom service?

Do you have other special needs? (Please explain) _____

Please check the mobility aid(s) that you use.

<input type="checkbox"/>	Manual Wheelchair	<input type="checkbox"/>	Powered Chair/Scooter
<input type="checkbox"/>	Cane for the Blind	<input type="checkbox"/>	Walking Cane
<input type="checkbox"/>	Service Animal	<input type="checkbox"/>	Walker
<input type="checkbox"/>	Crutches	<input type="checkbox"/>	Braces
<input type="checkbox"/>	Other	<input type="checkbox"/>	None

Would you be interested in learning how to ride DDOT's fixed route buses? ___ Yes/No ___

Do you need information provided in an alternative format or language? ___ Yes/No ___

Are you currently enrolled in MetroLift ADA paratransit service? _____ Yes/No _____

If yes, what is your MetroLift ID #: _____

The professional verification form that was provided with your application will be used to determine eligibility.

If no, would you like to enroll?

___ Yes. Please send me application information for MetroLift ADA Paratransit Service.

___ No. I do not want to enroll in MetroLift ADA Paratransit Service.

I understand that New Freedom is a federally funded grant program. I attest that the above information is true and correct to the best of my knowledge. I also understand any of the above information found to have been intentionally falsified will lead to immediate termination from this program.

Signature _____ Today's Date _____

Please return this form to the following: Special Fares Division, 100 Mack Ave, Detroit, MI 48201

***Note: Applications not accompanied by a copy of valid Michigan identification, phone number, address and completed professional verification form will be denied as incomplete.**

OFFICE USE ONLY: Date Received _____ Date Entered _____ Staff _____ Client I.D. # _____



PROFESSIONAL VERIFICATION FORM

The Detroit Department of Transportation (DDOT) provides complementary paratransit service via MetroLift and New Freedom Programs. The information provided below will be utilized to determine the applicant’s eligibility for complementary paratransit service in both programs. Please respond to the questions below pertaining to the applicant’s functional limitation as it is related to using public transportation. Thank you for your cooperation in this matter.

Please check your professional title:

<input type="checkbox"/>	Physician – MD, DO	<input type="checkbox"/>	PT/OT	<input type="checkbox"/>	RN/NP
<input type="checkbox"/>	P.A., N.P.,D.C.	<input type="checkbox"/>	Social Worker	<input type="checkbox"/>	Rehabilitation Specialist
<input type="checkbox"/>	Chiropractor	<input type="checkbox"/>	Optometrist	<input type="checkbox"/>	Certified Orientation & Mobility Specialist

Applicant’s Name: _____ D.O.B: _____

Describe the applicant’s functional limitation that qualifies him/her for paratransit service (The response should include more than the diagnosis):

How does the applicant’s functional limitation prevent him/her from traveling using DDOT fixed route public transportation? Please provide details so it is clear why the applicant is in need of this specialized service.

Is the condition temporary?: Yes _____ No _____

If yes, please explain the length of the condition and the circumstances: _____

Which of the following major life activities are substantially limited by the applicant's condition:

	Walking		Seeing		Sitting
	Speaking		Hearing		Standing
	Breathing		Learning		Lifting
	Performing manual tasks		Caring for oneself		Other:

Are there any other effects of the applicant's condition that impact his/her functional inability to use the fixed route bus?

Does the client require a Personal Care Attendant? Yes ___ No ___

Professional Signature ONLY (PLEASE PRINT CLEARLY)

I certify under penalty of perjury under the laws of the State of Michigan that the information contained in this application is true and correct.

Print Name & Title: _____

Office Address: _____

State of Michigan License, Certification, or Registration Number: _____

City: _____ State: ___ Zip Code: _____ Telephone Number: _____

Signature: _____ Date: _____

Please return this form to the following: DDOT New Freedom, 100 Mack Ave, Detroit, MI 48201

OFFICE USE ONLY: Date Received _____ Date Entered _____ Staff _____ Client's I.D. # _____