

PROFESSIONAL VERIFICATION OF FUNCTIONAL DISABILITY

(Do NOT Duplicate—Return Original Only)

To be completed by Applicant:

Applicant Name: _____

Date of Birth: _____

- I am applying for ADA paratransit service provided by *The Rapid* for individuals who cannot use fixed-route bus because of a disability.
- I authorize the release of the information described below to *The Rapid*.

APPLICANT NAME (printed): _____

APPLICANT SIGNATURE: _____

To be completed by Physician, Licensed Social Worker or Rehabilitation Specialist:

NOTE TO THE PHYSICIAN/REHABILITATION PROFESSIONAL

The Americans With Disabilities Act of 1990 (ADA) requires that public transportation must provide transportation to those who cannot access the regular city bus system. Paratransit service is not available to all persons with disabilities. Paratransit service is only available to those who are unable to independently board, ride and disembark a fixed-route vehicle.

PLEASE NOTE: All *Rapid* buses are equipped to allow passengers who use wheelchairs or other mobility aids to board and ride.

In assessing eligibility we look to an applicant's physician, rehabilitation professional or licensed social worker to provide medical verification as to the person's ability to access the fixed-route system.

Please answer the questions on the attached form concerning your patient. The information you provide will assist us in determining your patient's ability to use *The Rapid* bus system.

1. Are you currently treating this applicant?
 YES NO
 2. If no: date last time you saw this applicant: _____
Month Day Year
 3. Is this condition temporary?
 YES NO
- If yes, expected duration until: _____
Month Day Year

4. How many blocks can the person travel without another person but with using mobility aid if necessary

- less than one
- 2 blocks
- 4 blocks (1/4 mile)
- 8 blocks (1/2 mile)
- more than 8 blocks
- other (explain)

5. Can the patient climb three 12" steps? YES NO

6. Can the patient wait for up to 30 minutes without support? YES NO

if no, why not _____

7. Does the applicant experience significantly increasing fatigue throughout the day?

- YES
- NO

8. Does the patient use any of the following mobility aides?

- Manual Wheelchair
- Electric Wheelchair
- Cane
- White Cane
- Crutches/Braces
- Power Scooter
- Portable Oxygen
- Service/Guide Dog
- Walker
- None of the above

9. Any environmental issues that may make travel unsafe or risky?

- extreme heat/cold
- ice or snow
- poor air quality
- other

II. VISUAL IMPAIRMENTS

If vision limits the applicant's independent travel ability, please answer the following:

1. Prognosis: stable degenerative other

2. Can the patient recognize familiar places landmarks or destinations? YES NO

3. Is the applicant legally blind? YES NO

3a. Visual Acuity: (with best correction)

Right Eye _____ Left Eye _____ Both Eyes _____

3b. Visual Fields:

Right Eye _____ Left Eye _____ Both Eyes _____

4. Has the applicant received any travel instructions? YES NO

If yes, when and with whom?

III. COGNITIVE DISABILITY

I. Is the patient able to:

- A. Give address, phone number? YES NO
- B. Recognize destination/landmarks? YES NO
- C. Ask for and follow instructions? YES NO
- D. Safely cross major intersections? YES NO

IV. ARE THERE ANY OTHER FACTS OF WHICH *THE RAPID* SHOULD BE AWARE?

YOUR NAME: _____
(PLEASE PRINT) (CREDENTIALS)

OFFICE ADDRESS: _____

OFFICE PHONE#: _____ OFFICE FAX#: _____

SIGNATURE with CREDENTIALS: _____