

PROFESSIONAL VERIFICATION OF FUNCTIONAL DISABILITY

Please send to: adaapps@ridetherapid.org

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 buses 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 for 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

If no: date last time you saw this applicant: _____

What physical and/or mental diagnosis prevents this applicant from independent travel?

2. Is this condition temporary? YES NO

If yes, expected duration until: _____/_____/_____ (Month/Day/Year)

3. 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 aids?
 Manual Wheelchair Electric Wheelchair Crutches/Braces
 Walker Power Scooter White Cane Cane
 Portable Oxygen Service/Guide Dog 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

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? _____

COGNITIVE DISABILITY

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

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: _____