Part C-Professional Verification

INFORMATION RELEASE FORM FOR MOUNTAIN LINE PARATRANSIT APPLICATION

Applicant: _____Date of birth: _____

To evaluate your request for paratransit eligibility, it may be necessary to contact a professional to confirm the information you have provided or to answer additional questions. The individual completing Parts A and B of the application **cannot** be the person (s) listed below. This information release form must be completed by the applicant or an authorized representative (legal guardian) of the applicant.

The following professional is familiar with my disability, health condition, and functional abilities and is authorized to provide the required information to the Mountain Line Paratransit eligibility team.

Health Care Professional:

Physician_____ Nurse Practitioner_____ Physician Assistant_____ Physical Therapist _____Rehabilitation Therapist_____ Case Manager _____Social Worker _____Other (please explain)_____

_____

Name_____

Address_____

Phone_____Fax_____

I, _____ (printed name), hereby authorize the professional listed above to release information in writing or verbally to the Mountain Line Paratransit eligibility team to verify documentation of functional abilities. The information will be used solely for determining eligibility for paratransit certification.

In addition, I authorize the Mountain Line eligibility team to contact the professional listed above to verify documentation of functional abilities.

Applicant's Signature or Mark_____Date_____

Witness_____Date _____

If you have questions regarding ADA Paratransit Eligibility or the application process,

please contact our Eligibility Specialist at 928-679-8911

PART C-PROFESSIONAL VERIFICATION

Please take this section of the application to a professional for verification of your disability and your functional abilities. We prefer that this section be filled out by someone who is not only familiar with your diagnosis, but who is also familiar with your mobility. We suggest taking this form to a Case Manager, Social Worker, or Health Care Professional. If you have any questions regarding which professionals will be accepted or if the professional you have chosen is charging you a fee for the completion of this paperwork, please call our Eligibility Specialist at (928) 679-8911.

GUIDELINES FOR PROFESSIONAL VERIFICATION

Your patient/client has requested eligibility for Mountain Line Paratransit service. Because of your professional relationship with this applicant, you are uniquely qualified to help clarify his or her functional abilities and limitations. The following are guidelines for using Paratransit. These guidelines may help you in understanding the types of information we need to determine the applicant's eligibility for Paratransit.

The basis for Mountain Line ADA eligibility is the American with Disabilities Act. Eligibility is based on:

- Functional ability to independently perform the tasks necessary for bus use including: getting to and from the bus stop, getting on the bus, riding the bus, and understanding how to navigate the system in a variety of environments. A diagnosis by itself does not qualify an individual for Paratransit Eligibility.
- Whether the individual is prevented from performing these tasks (as opposed to the task being more inconvenient or difficult)
- Whether the individual can perform these tasks all the time, only under some circumstances, or if the disability would always prevent the individual from performing these tasks. Eligibility is unique to the individual's personal functional ability and reflects the patient's ability to use the bus and under what circumstances (ex: could use the bus if it was not more than two level blocks to the bus stop, and there was no snow or ice present).

INFORMATION WE NEED YOU TO PROVIDE

You may expand on, in as much detail as you can provide, how this individual's disability may impact his/her ability to travel on a bus. Please relate your comments to the specific tasks necessary to board, ride, and navigate the transit fixed-route system by describing how each condition limits his/her functional ability in these specific areas.

The following is a list of specific points which can serve as a guide for your report to Mountain Line Paratransit Services. Please address any of the following points that apply to the applicant on the form provided (pages 4-8):

- **Specific diagnosis and prognosis** of **each** of your patient's disabling conditions. Identify which of these conditions you are currently treating.
- **Specific measurements**
    - **For the visually impaired:** visual acuity measurements and visual field readings for both eyes
    - **For the cognitively impaired:** I.Q. scores and Adaptive Behavior scores
- **Date of onset**
    - **Prognosis:** If the individual has a progressive disease or condition, or if s/he is expected to improve or recover. Provide the best estimate of the rate at which this is expected to occur, and if therapy is part of the treatment plan.
- **Mobility Impairments**
    - Can the individual walk?
    - Under what conditions can s/he walk?
    - Under what conditions can s/he not walk?
    - What mobility aids does s/he use?
    - How long has s/he been using this device?
    - How far can s/he walk/travel independently using mobility aids?
    - How do weather conditions (rain, ice, snow) affect his/her mobility?
    - How are balance and endurance affected?
- **Neurological Impairments or Head Injuries**
    - Is judgment or behavioral inhibition impaired, and to what extent?
- **Seizures**
    - What type of seizures?
    - Are they controlled by medication?
- **Emotional and/or Behavioral Problems**
    - Is judgment impaired?
    - Does s/he experience disabling anxiety, auditory or visual hallucinations, delusions, etc.?
    - General Information
    - Would the individual need the help of an assistant or companion to ride the bus?
    - How do temperature fluctuations affect his/her functioning?

PART C-PROFESSIONAL VERIFICATION

Applicant Name _____Date of Birth_____

Applicant Address _____

Applicant Contact Phone Number (s) _____

In what capacity, do you know this individual? _____

_____

How long have you known this individual? _____

What is the last date of in person contact (by you or your agency) with this individual? _____

Primary Disability and/or Health Condition: _____

_____

a. Date of onset: _____
b. Prognosis: _____
c. Expected duration of condition: _____
d. Are the effects of the disability variable? _____Yes _____No

Secondary Disability and/or Health Condition: _____

_____

a. Date of onset: _____
b. Prognosis: _____
c. Expected duration of condition: _____
d. Are the effects of the disability variable? _____Yes _____No

Current medications and/or medical treatments. Please attach list if additional space is required.

Name of Medication/Treatment	Date Prescribed

Medication/Treatment side effects reported by patient/client: _____

_____

_____

_____

_____

How does the above medication and/or medical treatments affect the individual's functional ability to travel independently within the community (ex: drowsiness, confusion, nausea, weakness, gait/balance instability, etc.)? _____

_____

_____

_____

_____

INFORMATION ON TRAVEL CHALLENGES

Please use this space to elaborate how the applicant's disability affects his/her ability to travel independently. Please relate your comments to the specific tasks necessary to board, ride, and navigate the transit fixed-route system by describing how the individual's condition limits his/her functional ability in these specific areas. Our determination is **not** based on income or the inability to drive a vehicle.

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For the following questions, please provide information regarding the applicant's functional abilities, taking into consideration any mobility aid used if applicable.

What type of mobility aid and/or adaptive equipment does the individual use?

☐NA

☐Scooter	☐Power Wheelchair	☐Manual Wheelchair
☐Wheeled Walker	☐Support Cane	☐Cane
☐Crutches	☐Walker	☐Prostheses: _____
☐Leg Braces	☐Portable Oxygen	☐White Cane
☐Monocular	☐Telescope	☐Electronic Travel Device
☐Service Animal	☐Hearing Aid	☐ASL Interpreter
☐Voice Box	☐Picture Board	☐Alphabet Board
☐Language Interpreter		☐Other:

Does the individual have a visual impairment? _____Yes _____No

If yes, please answer the following questions.

Eye Disease or condition: _____

Visual acuity measurements and visual field readings: _____

_____

Vision is worse during these conditions: _____Bright sun _____Low light _____Darkness

Individual has: ____ No vision _____ Night blindness

Maximum distance individual can travel <u>independently</u> using a mobility aid if necessary? _____feet

____330 ft.	____1320 ft. (< 16 min)	____2310 ft.
____660 ft.	____1650 ft.	____2640 ft. (< 32 min)
____990 ft.	____1980 ft.	

Would the individual exhibit any signs of distress at the maximum distance? _____Yes _____No

If yes, please explain: _____

_____

_____

Do weather conditions affect the individual's ability to travel independently? _____Yes _____No

If yes, what types of weather conditions make independent travel difficult?

_____Hot _____Cold _____Rain _____Wind _____Snow _____Ice _____ Humidity _____Other

Explain how the above weather conditions affect his/her independent travel:

_____

_____

Please respond to the following statements regarding his/her ability to complete tasks related to use of the accessible fixed-route bus service. The answers should be based on his/her ability to perform these tasks *independently*, using an assistive device if applicable. Read each statement carefully and check the appropriate box.

INDIVIDUAL CAN:	YES	NO	SOMETIMES
1. Use the telephone to obtain information or assistance			
2. Obtain and comprehend information such as a bus schedule and directions for path of travel			
3. Communicate needs, ask for and understand instructions			
4. Recognize, exchange and comprehend printed information			
5. Recognize, exchange and comprehend spoken words or auditory information			
6. Understand how to tell and monitor time			
7. Understand distances traveled			
8. Safely travel along sidewalks and other pedestrian ways			
9. Recognize curbs, curb cuts, steps and other drop offs			
10. Locate and initiate safe crossings at streets or intersections with or without pedestrian crossing signs			
11. Safely and effectively travel through crowded and/or complex facilities			
12. Problem solve if an unexpected situation arises such as encountering a barrier along the path of travel or if a bus must make a detour			
13. Locate and recognize the correct bus from signage or auditory information			
14. Identify and deposit the correct fare into the fare box or scan a bus pass			
15. Recognize destinations, bus stops or landmarks			
16. Recognize when and how to signal for a stop			
17. Understand and implement strategies for personal safety when traveling			

Please respond to the following statements regarding his/her ability to complete tasks related to use of the accessible fixed-route bus service. The answers should be based on his/her ability to perform these tasks *independently*, using an assistive device if applicable. Read each statement carefully and check the appropriate box.

INDIVIDUAL CAN:	YES	NO	SOMETIMES
1. Travel one block on a clear, level sidewalk • If so, how long does it take?			
2. Travel three blocks on a clear, level sidewalk • If so, how long does it take?			
3. Travel up or down a gradual hill on a clear sidewalk • If so, for what distance?			
4. Navigate around obstacles along the path of travel			
5. Negotiate on broken pavement or surfaces			
6. Negotiate on uneven or grassy surfaces			
7. Negotiate on gravel surfaces			
8. Negotiate on loose dirt or sandy surfaces			
9. Negotiate on snow covered or icy surfaces			
10. Maneuver up and down a curb cut			
11. Maneuver up and down a 6” curb			
12. Wait ten minutes at a bus stop that does not have a seat or shelter			
13. Walk up and down three steps if there are handrails on both sides			
14. Climb bus steps from street level without a curb			
15. Negotiate up /down bus ramp from street level			
16. Ambulate or wheel to a seat or wheelchair securement area			
17. Ride in a seated or standing position while vehicle is in motion			

Please check any of the following affected by the individual's disability.

____Disorientation

____Problem solving

____Short term memory

____Long term memory

____Gait or balance

____Other (Please explain)

____Monitoring time

____Judgement

____Communication

____Inconsistent performance

____Inappropriate social behavior

____ (Please explain)

_____

_____

_____

Would transit travel training be appropriate for this individual? ____Yes _____No

Please explain: _____

_____

What training tools, if any, would be of help with fixed-route travel (ex: memory cards, written route directions, photos)?_____

_____

_____

Is the goal of traveling independently on the fixed-route system within the context of treatment?

_____Yes _____No

Please describe how having access to Paratransit will better suit this individual than using the fixed-route system. Include any additional information regarding the individual's functional ability and/or special circumstance which may assist in our determination.

_____

_____

_____

_____

_____

_____

I certify that this information is true and correct to the best of my knowledge.

Signature _____ Title_____

_____ _____

Please print or type name Please print or type title

Agency_____ Date_____

Address_____ Phone_____

_____ Extension_____

_____ Fax_____

Thank you for your time and input.

Please return the completed form via:

Fax: 928-779-6868 or

Mail: Mountain Line/Paratransit Eligibility
3773 N. Kaspar Drive
Flagstaff, AZ 86004