Professional Medical Verification Form for ADA Paratransit

INSTRUCTIONS FOR COMPLETING THIS FORM

The Americans with Disabilities Act of 1990 (1990) is a civil rights act that requires public transit agencies to provide Paratransit service to people whose disabilities prevent them from using a bus some or all the time. The information you provide will enable us to make an appropriate determination for this applicant. All information will be kept confidential. Thank you for your assistance.

PROVIDERS please note:

Access-a-Ride service is for individuals unable to utilize the fixed route bus and rail system due to:

a) physical, cognitive or visual impairments that require assistance from another person

b) impairments related to accessible travel to/from embarking locations

Paratransit service is for individuals who are unable to use fixed route service some or all of the time as a result of their disability. **RTD's bus and rail vehicles are fully accessible**.

Health care providers who can complete this form (must be treating the disability for which applicant is applying for paratransit service):

Physician/PA/NP

Social Worker (MSW)

Orientation & Mobility Specialist

Ophthalmologist/Optometrist

Rehabilitation Counselor

RN/ PT / OT/ SLP

Psychiatrist/Psychologist

Mental Health Clinician

Respiratory Therapist

Applicant: Please sign the below Release and provide the form to your health care provider for completion.

Authorization for Release of Information

I hereby authorize the above-named professional to provide information about my disability and abilities to use bus service to the Regional Transportation District (RTD) and/or persons assisting RTD in determining my eligibility for Access-a-Ride service. I understand that this information will be used solely for the purpose of determining my eligibility for Access-a-Ride service and that all medical information about my disability will be kept confidential.

I also understand that, at no expense to me, RTD will require that I participate in an in-person evaluation of my travel skills and agree to such an evaluation.

____ ____________

Signature of **Applicant** or Responsible Party Date

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FORM TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Applicant name: ____________________ **D.O.B.:** __________ **Phone number:** _________

Professional name: ___________________ **Professional phone:** ___________________

Length of time treating this individual: ___________ **Most recent visit:** ______________

How does the applicant's disability prevent applicant from performing the following tasks?

*****Getting to or from a bus stop: ____

*Navigating the bus system: ____

Impairments are: ☐ Stable ☐ Progressive ☐ Degenerative ☐ Temporary, duration: ________

Does applicant require assistance when traveling outside the home? ☐ Yes ☐ No

Can this applicant travel without supervision? ☐ Yes ☐ No

Does the applicant have the mental capacity, visual and/or hearing ability to:

Ask for, understand and follow directions? ☐ Yes ☐ No

Ask for assistance from appropriate sources? ☐ Yes ☐ No

Judge traffic flow to safely cross a major street? ☐ Yes ☐ No

Safely travel through crowded/complex facilities? ☐ Yes ☐ No

Filter environmental noise? ☐ Yes ☐ No

Locate steps or curb cuts? ☐ Yes ☐ No

Regarding vision impairments only, applicant is impacted by:

☐ N/A ☐ Applicant is blind ☐ Bright unlight ☐ Dimly lit conditions ☐ Night/Darkness

Regarding this applicant's mobility, is applicant able to independently perform the following tasks (using their primary device if indicated):

Travel to and from a vehicle? ☐ Yes ☐ No

Travel up or down hills? ☐ Yes ☐ No

Wait for up to 15 minutes with support? ☐ Yes ☐ No

Travel the following?: **4 blocks:** ☐ Yes ☐ No **3 blocks** ☐ Yes ☐ No

2 blocks ☐ Yes ☐ No **1 block:** ☐ Yes ☐ No

Less than 1 block: ☐ Yes ☐ No

Does weather impact the applicant's ability to travel? ☐ Yes ☐ No

☐ **Wind** **Cold** ☐ <30º ☐ <40º ☐< 50º **Heat** ☐ >70º ☐ >80º ☐ > 90

Signature of Provider:_________________________ **License number:**________

Date: _______

Please return completed form <u>to the applicant</u>, *OR* fax it to 303-299-2169.

****FORMS WITHOUT SIGNATURE AND LICENSE NUMBER WILL DELAY PROCESSING****