Paratransit Eligibility Application

419 Bradley Dr. · PO Box 11286 · Lynchburg, VA 24506
Phone: 434-455-5080 · **Fax:** 434-616-3138

Form II: Health Care Professional Verification

To be completed by a physician or an approved health care professional only.

This part of the application is for paratransit (van) services under the Americans With Disabilities Act (ADA).

Please **PRINT** or **TYPE**. Use additional sheets if needed. Complete all sections which are relevant to the applicant's disabilities.

The Greater Lynchburg Transit Company (GLTC) provides paratransit services (curb-to-curb only transportation provided in lift-equipped vans) to individuals who cannot utilize our fixed route service (our regular large bus system). To be eligible for this paratransit service, indoviduals must have one or more physical or mental disabilities which prevent use of the fixed route service. *Neither age, economic status, nor distance to the nearest bus stop by themselves constitutes eligibility.*

Please answer the following questions as they pertain to _____ who has asked us to forward this application to you on his/her behalf.

As a professional familiar with the applicant's medical history, please complete this form documenting the disability or condition that prevents his or her use of the regular bus system. Please assist us by certifying only those individuals that are truly unable to use the regular bus system.

A. General Information *Complete for all applicants*

Capacity in which you know this person?

_____

_____

What disability(ies) prevent(s) this person's use of a regular fixed route service?

_____

_____

Form II: Health Care Professional Verification (cont.)

How does the disability(ies) prevent(s) the use of a regular fixed route service?

_____

_____

Is this temporary? ☐ Yes ☐ No if "Yes", expected duration? _____

B.Physical Mobility *Complete for applicants whose disability physically limits his/her mobility*

Does this person use any of the following mobility aids:

- ☐ Manual Wheelchair
- ☐ Electric Wheelchair
- ☐ Powered Scooter
- ☐ White Cane (for the visually-impaired)
- ☐ Crutches
- ☐ Walker
- ☐ Service Animal
- ☐ Walking Cane
- ☐ Portable Oxygen
- ☐ Personal Assistant/PCA Crutches
- ☐ Other _____

If this person uses a riding mobility aid, how many blocks can he/she travel without help?

(One block= approx. 500 ft.) _____ Blocks

How does this person's disability prevent him/her from traveling more blocks?

_____

If this person uses a riding mobility aid (i.e. wheelchair or scooter), can he/she get on and off of a wheelchair lift independently if our Fixed route services were equipped with lifts and handrails?(lifts would be operated by the drivers) ☐ Yes ☐ No

If "No", please explain why not:

_____

If this person can walk, with or without a mobility aid, how many blocks can he/she walk without help? Blocks

How does this person's disability prevent him/her from traveling more blocks?

_____

How many 9-inch steps can this person climb without help? _____

How does this person's disability prevent him/her from climbing more?

_____

Form II: Health Care Professional Verification (cont.)

If this person is unable to climb steps, could he/she stand, hold onto handrails, and ride up into a bus on a wheelchair lift if our Fixed route services were so equipped? (Lifts would be opened by the drivers.)

☐ Yes ☐ No

If "No", please explain why not:

_____

How many minutes can this person wait at a bus stop? _____

How does this person's disability prevent him/her from waiting longer?

_____

_____

C. Cognitive Ability *Complete for applicants with a cognitive disability*

Can this person read informational signs? ☐ Yes ☐ No

If "No", please explain why not:

_____

Can this person navigate independently? ☐ Yes ☐ No ☐ Sometimes

If "No" or "Sometimes", please explain:

_____

Can this person give his/her address, destination and telephone number upon request?

☐ Yes ☐ No ☐ Sometimes

If "Sometimes", please explain when:

_____

Can this person recognize a destination or landmark?

☐ Yes ☐ No ☐ Sometimes

If "Sometimes", please explain when:

_____

Can this person ask for, understand, and follow directions?

☐ Yes ☐ No ☐ Sometimes

If "Sometimes", please explain when:

_____

Form II: Health Care Professional Verification (cont.)

Can this person give his/her address, destination and telephone number upon request?

☐ Yes ☐ No ☐ Sometimes

If "Sometimes", please explain when:

_____

C. Cognitive Ability *Complete for applicants with visual impairment*

Can this person read informational signs? ☐ Yes ☐ No

If "No", please explain why not:

_____

Can this person navigate independently? ☐ Yes ☐ No ☐ Sometimes

If "No" or "Sometimes", please explain:

_____

Has this person received mobility training? ☐ Yes ☐ No ☐ Unknown

If "No", is this person on a waiting list to be mobility trained? ☐ Yes ☐ No ☐ Unknown

If "Yes", approximately when will the training begin? _____

E. General Ability *Complete for all applicants*

What specific weather conditions, if any, affect this person's mobility? Please explain completely.

_____

_____

What terrain or road and sidewalk conditions, if any, affect this person's mobility?

_____

_____

Will this person require any assistance while traveling on our vehicle?

☐ Never ☐ Always ☐ Sometimes

If "Always" or "Sometimes", please explain what, why, and when.

_____

_____

Form II: Health Care Professional Verification (cont.)

Will this person require a personal attendant/PCA while traveling on our vehicle?

☐ Never ☐ Always ☐ Sometimes

If "Sometimes", please explain when.

_____

_____

Please explain any other functional limitation(s) affecting this person's mobility not described above. Be specific.

_____

_____

_____

In your professional opinion, does this applicant's disability prevent him/her from getting to or from, boarding, riding, or disembarking a regular Fixed route service?

☐ Yes ☐ No ☐ Sometimes

_____ _____

Signature of Health Care Professional **Date**

Name and Title: _____

Office Address: _____

City/State/Zip: _____

Office Telephone: _____

Please Return Completed form to:

GLTC

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