Dear Healthcare Professional:

The patient listed on the accompanying release form is applying for Grand Valley Transit Paratransit Service. The information you provide in answering the questions on the enclosed questionnaire will aid Grand Valley Transit in making a Paratransit eligibility determination. Please keep in mind this document is time sensitive.

Because demand for this service is high, qualification criteria are stringent. For the benefit of the applicant please answer all of the questions completely and accurately. Please return completed questionnaires to the applicant so that they can return the completed packet to Grand Valley Transit.

In accordance with Americans with Disabilities Act (ADA) guidelines, Paratransit service is available only for persons who have disabilities that prevent them from traveling on Fixed Route Buses. The individual could be prevented by inability to independently get to and from a bus stop, on or off a bus, or to successfully navigate to a destination. Please keep in mind that ADA Paratransit eligibility is not based on age, a medical condition, the inability to drive, or the use of a particular mobility aid. The severity of a disability does not confer eligibility. Comfort and convenience are not factors. ADA Paratransit eligibility is based on the EFFECT that a disability has on your client's ability to use the regular Grand Valley Transit accessibly-equipped Fixed Route Bus system.

All information provided will remain confidential. If you have any questions, please call 970-623-8469.

Thank you for your assistance,
Grand Valley Transit Paratransit Services

Patient Information

This information is needed in case the Health Provider Application is turned in without the Applicant's application. Thank you!

Patient's Name: _____

Patient's Address: _____

Patient's Phone Number: _____

General Disability Questions

Describe the diagnosed disability or disabilities that you are currently treating this individual for?

_____
_____
_____
_____
_____
_____

Check all that apply

Is the patient's disability:

☐ Permanent ☐ Stable ☐ Progressive ☐ Temporary

How long? Months: _____ Years: _____

Does your client's disability:

☐ Affect mobility ☐ Affect judgment ☐ Require use of a mobility aid

Can your client:

A. Walk two blocks (600 feet) with their mobility aid? ☐ Yes ☐ No
B. Climb three standard steps without assistance? ☐ Yes ☐ No
C. Stand without support for 15 minutes? ☐ Yes ☐ No
D. Walk or stand without debilitating pain or discomfort? ☐ Yes ☐ No
E. Board or de-board a fixed route bus equipped with a lift or ramp? ☐ Yes ☐ No
F. Recognize correct stops and landmarks to complete a trip? ☐ Yes ☐ No
G. Hear and understand verbal information? ☐ Yes ☐ No
H. Read and understand informational signs? ☐ Yes ☐ No
I. Plan a trip using public transportation? ☐ Yes ☐ No
J. Communicate information about themselves? ☐ Yes ☐ No

Disability Specific Questions

ICD 11/DSM Code for the condition(s) you are treating: _____
WHODAS Score (if citing a cognitive or psychological disorder): _____

Please only complete those questions that apply to the applicant for this section.

Does the applicant experience seizures? ☐ No ☐ Yes

Is the applicant's judgment impaired? ☐ No ☐ Yes

Does this condition affect the applicant's ability to move independently outside their residence or a supervised environment?
☐ No ☐ Yes

Does the applicant experience any hallucinations, delusions, or disassociation? ☐ No ☐ Yes

Does this prevent the applicant from being oriented to person, place, & time? ☐ No ☐ Yes

Please describe any triggers that may cause psychological disorders to manifest.

_____
_____
_____
_____
_____
_____
_____

Please describe the functional limitations caused by this impairment.

_____
_____
_____
_____
_____
_____
_____

Mobility and Safety Questions

Does the applicant have a visual impairment that affects their ability to move about in the environment?

☐ No ☐ Yes If yes, please explain: _____

_____

_____

_____

_____

Has the applicant received any orientation & mobility training?

☐ No ☐ Yes If yes, please explain: _____

_____

_____

_____

_____

Please list any side effects of medication the applicant experiences that could affect transporting them safely.

_____

_____

_____

_____

_____

Would you like to add any additional comments on the functional ability of the applicant?

_____

_____

_____

_____

Provider Affirmation

Address (Street number, City, State, Zip): _____

Provider UPIN # or Tax ID: _____

Employer / Agency: _____

I am a licensed medical provider or qualified service provider and certify that the above-mentioned individual has the disability and limitations indicated above.

Provider Signature: _____ Date: _____

Provider Name (printed): _____