101 11th Avenue
Greeley, CO. 80631
Phone (970) 350-9290
Fax (970) 350-9285

REQUEST FOR PROFESSIONAL VERIFICATION
(To Be Completed by Health Care Provider Only)

Dear Physician or Health Care Provider,

PLEASE FILL OUT ONLY SECTIONS THAT APPLY

Your patient, who is also one of our riders of Greeley Evans Transit, has applied for Paratransit Service. Documentation of the applicant's disability or health condition must be provided by the applicant's health care provider. The information that you provide will help us to evaluate what the mode of transportation is most appropriate for the applicant.

Please return this verification to your patient, or you may send to us directly. **Failure to provide this information** will result in your patient's application being denied and the application will be deemed incomplete. This may result in another request for this form in the future if the patient chooses to reapply.

The information obtained in this certification process will be used only by GET for the provision of transportation services and making a determination of ADA eligibility. This information will not be provided to any other person or agency.

Please complete this professional verification as thoroughly as possible. **All health care providers should complete Section A. Please complete all subsequent sections that apply.** Should you have any additional questions, please do not hesitate to call.

Applicant's Name: **Date of Birth:**
Address (Please include city)**:**

SECTION A-GENERAL QUESTIONS

(Please answer all questions in Section A)

1. In what capacity do you know this applicant? _____

   a. How long have you known this applicant? _____ _____

   b. Last date of face to face contact (by you or your agency)_____

2. **Does the applicant have a disability**? □Yes □ No

If yes, please describe the disability and how it limits their daily life activities:
_____
_____
_____
_____

3. Date of onset? _____

4**. Is the disability permanent**? □Yes □ No

If no, expected date of recovery: _____

SECTION B-PHYSICAL DISABILITIES

(If applicable, otherwise skip to Section C)

1. Diagnosis/Prognosis? _____
_____

2. **Will condition/disability prevent them from independently using fixed-route bus service**? _____
_____

3. Does the applicant need a **personal care attendant** when traveling?
□Yes □ No

4. Please identify the travel skills they are able to perform without placing themselves at risk of exacerbating their health condition or disability. If using mobility device (including a wheelchair/walker) answer considering that device will be used:

a. travel up to (please check longest distance)

□ **Less than 200 feet**
□ **1/4 mile (3 blocks)**
□ **1/2 mile (6 blocks)**
□ **3/4 mile (9 blocks)**
□ **More than 3/4 mile**

b. in a reasonable amount of time**, safely cross streets**?
□Yes □ No □ Sometimes

c. negotiate slight/moderate/steep terrain, cross slopes?
□Yes □ No □ Sometimes

d. travel in snow/icy surfaces? □Yes □ No □ Sometimes
very cold weather? □Yes □ No □ Sometimes
hot or humid weather? □Yes □ No □ Sometimes

e. **transfer to a second bus**? □Yes □ No

f. wait at a bus stop if there is no bench?
□Yes □ No □ Sometimes

g. get on and off buses using a lift or ramp?
□Yes □ No □ Sometimes

h. get to a seat or wheelchair securement on a bus?
□Yes □ No □ Sometimes

i. stand on a moving bus holding the handrail?
□Yes □ No □ Sometimes

5. Medications that would affect the applicant's ability to travel?
□Yes □ No

SECTION C-COGNITIVE IMPAIRMENTS

(If applicable, otherwise skip to Section D)

1. Diagnosis/description of the applicant's cognitive impairment?

_____
_____
_____

2. Prognosis?

_____
_____
_____

3. What is the general classification of cognitive ability?

□ Mild □Moderate □ Severe □ Profound

4. Specific behavioral problems? □Yes □ No

If yes, please explain:

_____
_____

5. Does the applicant travel alone? □Yes □ No

6. **Does the applicant have the ability to:**

a. tell time? □Yes □ No
b. follow directions in order to make a trip? □Yes □ No
c. follow a schedule to get places on time? □Yes □ No
d. know when they are lost and get help? □Yes □ No
f. cross a street safely? □Yes □ No

g. communicate needs? ☐**Yes** ☐ **No**
h. recognize/avoid dangers traveling alone? ☐**Yes** ☐ **No**
i. transfer to a second bus? ☐**Yes** ☐ **No**

7. Would travel training be appropriate for this applicant?
☐Yes ☐ No

If no, why?_____

SECTION D-PSYCHIATRIC DISABILITIES

(If applicable, otherwise skip to Section E)

1. What is the applicant's diagnosis? (DSM-IV) _____

2. Prognosis? _____

3. Is person taking psychotropic, antidepressant, or other medication?
☐Yes ☐ No

4. Is the applicant able to travel alone in the community? ☐Yes ☐ No-Not consistently

5**. Describe how the applicant's disability affects his/her ability to complete the following skills:**

- **Seek and act on directions _____**
- **Find way to/from bus stop _____**
- **Cross streets _____**
- **Wait for a bus _____**
- **Board the correct bus _____**
- **Transfer to a second bus _____**
- **Exit at correct destination _____**
- **Safe community travel_____**

6. Are any of the following affected by applicant's disability?

□ Disorientation □ Monitoring time □ Short term memory
□ Gait/Balance □ Communication □ Long term memory

□ Inappropriate social behavior

(□aggressive □sexual □ overly friendly) □ Other

7. Is applicant's disability the same every day? □Yes □ No

If not, please describe:

_____

SECTION E-SEIZURE DISORDERS

(If applicable, otherwise skip to Section F)

1. What type of seizures is the applicant experiencing? _____
_____

2. What is the frequency of the seizures? _____

3. Diagnosis? _____

4. Prognosis? _____

5. Are the seizures preceded by an aura? □Yes □ No

6. Is the applicant able to travel alone in the community? □Yes □ No

7. What advice or limitations on traveling alone in the community have been communicated?
_____
_____

8. Is the applicant taking medication? □Yes □ No

Do any of these medications produce side effects that will affect ability to travel in the community? □Yes □ No

Use public transportation? □Yes □ No

Please describe:

_____

_____

Temporarily affected by medication? □Yes □ No

If yes, please explain:

_____

_____

Expected duration? _____

SECTION F-VISUAL IMPAIRMENTS

(If applicable, otherwise skip to the signature section at the end)

1. Diagnosis? _____

a. Legally blind? □Yes □ No

2. Date of onset?_____ Prognosis?_____

4. Visual acuity: Left eye ____ Right eye ____ Both eyes ____

5. Visual fields: Left eye ____ Right eye ____ Both eyes ____

6. Visual acuity best correction: Left eye ____ Right eye ____ Both eyes ____

Mobility Skills Assessment (to be completed by O & M Specialist if applicable)

7. Can this applicant travel outside alone? □Yes □ No

8. Cross streets without help? □Yes □ No

If yes: What type of intersections/controls? _____
_____

9. See and negotiate curbs and steps? ☐Yes ☐ No

10. Travel to familiar places independently? ☐Yes ☐ No

11. Travel to unfamiliar destinations independently? ☐Yes ☐ No

12. What environmental conditions might impact travel outside?
_____

13. Has this applicant had mobility or travel training? ☐Yes ☐ No

If no, would applicant benefit from mobility or travel training? ☐Yes ☐ No

Please sign below

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

Signature _____ Title _____

_____
Please print or type name and title

Agency _____ Date _____

Address _____
Phone _____

Thank you for taking the time in providing your input. You may return this form by fax or mail to the information on the letterhead, or e-mail to Leiton.powell@greeleygov.com.

Sincerely,

Leiton K. Powell
Transit Operations Supervisor – ADA Specialist