



215 Iyannough Road, P.O. Box 1988, Hyannis, MA 02601
www.capecodrta.org
Phone: 508-775-8504 Fax: 508-775-8513

Part II

Professional Verification

DEAR HEALTH CARE PROFESSIONAL

The attached Application contains a form authorizing you to provide the CCRTA with information concerning his/her ability to ride regular CCRTA buses unassisted. The Applicant has indicated that you are familiar with their disability and can confirm his/her statements. He/she is applying for the Cape Cod Regional Transit Authority (CCRTA) ADA Complementary Paratransit Service. This service is origination to destination demand response service and customers must be able to meet the vehicle at street level for pickup.

Please read the following ADA (Americans with Disabilities Act) definition of a person with a disability:

Any person with a disability who is unable, as a result of a physical or mental impairment to board, ride or disembark from an accessible vehicle independently or complete transfers without the assistance of another individual.

And/or

Any person with a disability who has a specific impairment related condition that prevents them from traveling to and from a bus stop on the public bus system. Architectural and environmental barriers such as distance, terrain or weather do not, standing alone, form a basis for eligibility. However, consideration should be given to the interaction of environmental conditions (terrain and weather) with the individual's impairment related condition.

*****Please note:***

The applicant must be able to meet the driver at street level for pickup.

This applicant is able to use the service as outlined above. Yes ___ No ___

If no, please sign, date and submit form to CCRTA, P.O. Box 1988, Hyannis, MA 02601

Health Care Professional Signature

Date

Certification/Licensure

If you answered yes to the above question, please continue to the next page and answer all of the questions. Questions may be directed to CCRTA, Administrative Offices, 508-775-8504, x200.

While answering the following questions, keep in mind this information will be one element in the eligibility determination made by the transit provider's staff/contractor. Please verify the disability claimed by the applicant, the extent of this disability, and for functional assessments as to the applicant's ability to perform activities related to using a fixed route transit service. Your input will be particularly important where applicants have claimed a "hidden" or "non-visible" disability (e.g. a medical condition such as a cardiac or pulmonary condition, mental illness, or a joint disease etc.). This verification will also assist in determining the degree of cognitive capability.

1. How do you know this individual?

2. Have you examined/evaluated the applicant within the last twelve months? Yes _____ No _____ Length of time in treatment/under your care?

3. What is the applicant's specific disability or health condition/limitation and how does it limit his/her ability to travel independently?

(Please list the medical diagnosis and then describe the disability or health condition/limitation)

Use other side of page if necessary _____

Date of onset? _____

4. Due to the applicant's health condition or disability, how is the applicant's ability to ambulate impaired or limited? _____

5. What is the applicant's prognosis? _____

6. Will his/her ability to ambulate improve? Yes ___ No ___
If NO, please explain: _____

7. Is the applicant taking any medications? If yes, does the medication impair this person's ability to ambulate? Please explain. _____

8. Is this person's disability:
Permanent _____ Yes ___ No ___
Is this person's disability:
Temporary _____ Yes ___ No ___
If temporary how long? _____

Is this person's disability:
Seasonal _____ Which season(s)? _____

9. Can this individual board, ride and navigate (transfers) on an accessible bus?
(Keep in mind all vehicles are accessible)
Yes ___ No ___ If NO, please explain. _____

10. If the applicant uses a mobility aid, can he/she independently maneuver onto/off of a mechanical lift? (The driver operates the lift and helps with the securement system. Lifts have handrails.)
Yes ___ No ___

If NO, please explain. _____

11. If the applicant uses a riding mobility aid is he/she able to independently transfer to a seat in the vehicle. Yes ___ No ___

12. Does this person require a Personal Attendant/PCA when traveling on CCRTA accessible vehicles? (*Riders must provide their own PCA*)

Never _____ Sometimes _____ Always _____

If a PCA is needed, explain why. _____

13. Which of the following weather conditions impact the person's disability or health condition such that it prevents the individual from independently getting to and/or from a bus stop?

Indicate: Heat _____ Cold _____ Humidity _____

Snow _____ Ice _____ Other _____ N/A _____

What specific weather condition prevents this person from getting around on his/her own? How so? _____

14. Can the individual independently select the correct bus, recognize his/her destination and disembark and make transfers? Yes _____ No _____

If NO, please explain. _____

15. Is he/she able to: (check all that apply)

- Understand and/or process information
- Ask for, or follow written or oral information, such as schedules including TDD, audio tape or voice?
- Figure out the correct fare?
- Follow instructions in an emergency?
- Recognize his/her destination while on the bus?
- Once he/she gets off the bus, locate and reach his/her destination?
- Cross a busy intersection?

16. Is this individual able to travel 3 blocks (1/4 mile) with or without the use of a mobility aid? (wheelchair, walker, cane, crutches) Yes ___ No _____

17. If NO, please explain: _____

18. If the person ambulates to a bus stop, without a riding mobility aid, how long can the individual wait (not sitting) until the bus arrives?

30 minutes or longer ___ 15 minutes ___ 10 minutes ___
less than 10 minutes _____

If he/she cannot stand while waiting, why not? _____

Your Name and Title: _____

Certificate/Licensure: _____

Office Address: _____

Office Telephone Number: _____

Signature _____ Date: _____

Please forward the signed original to CCRTA at P.O. Box 1988, Hyannis, MA , 02601.
Questions may be directed to our Administrative Offices at 508-775-8504.

You may also fax a copy to 508.775.8513 to expedite the process, but the signed original must be forwarded to CCRTA. Thank you for your cooperation.