PARATRANSIT ELIGIBILITY APPLICATION CERTIFICATION OF HEALTH CARE PROVIDER

You are being asked by the applicant named in Part A of this application to provide information regarding his/her ability to use the regular fixed-route services provided by the transit systems in the region. For those persons who are not able to use the regular fixed-route services, with the accommodations provided, the transit system may allow them to use paratransit services. The information you provide will allow us to evaluate the request and determine this individual's specific needs. Thank you for your cooperation in this matter.

Please note: All regular fixed-route and connector services available within the region are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles which kneel to the curb, and/or announcement of bus stops. In order to be eligible for the paratransit services, the individual must be **unable** to access these services due to conditions which prevent them from getting to or from a fixed-route bus stop, or transferring between vehicles, and/or conditions which prevent them from being able to get on, ride, or get off a lift-equipped vehicle. Individuals for whom performing these tasks is inconvenient or uncomfortable are **not eligible** for services, and you are asked to verify this information.

It is extremely important that you provide specific information about the individual's functional limitations so that eligibility determination can be made.

Please follow these steps to verify this application:

1. Read the applicant's statements provided in Part A in its entirety
2. Fill out Part B completely using the criteria provided
3. Return completed application to applicant within 7 days of receipt (Applicant is responsible for returning application to paratransit provider)
4. Be aware that you may be contacted for further information about applicant's abilities
5. If you have questions, contact GoDurham ACCESS by calling (919) 550-1551

Applicant Name

Home Address **Apt/Suite/etc.**

City **Zip Code**

PART B - CERTIFICATION OF HEALTH CARE PROVIDER

1. I have read Part A in its entirety and I agree with the information provided.

☐ Yes ☐ No

If no, please explain:

2. Identify the condition causing this applicant's disability.

3. Specify which functional limitations are associated with this condition and be specific when asked to supply additional information.

- Mobility impairment
- Hearing impairment (Total Partial)
- Visual impairment (Total Partial)
- Compromised endurance (Muscular Respiratory)
- Other (Please specify):

What's the severity of the individual's condition?

Mild Moderate Severe Profound/chronic

***If this individual has functional limitations due to a cognitive impairment, please indicate any of the following issues that are pertinent to this individual:**

- Cannot be left alone to wait for transportation
- Displays behavior that is unsafe for self or others using public transportation
- Cannot recognize vehicles that she/he should board

What is the expected duration of this individual's condition?

- Temporary - Approximate until
- Long term - Potential for functional improvement or periods of remission
- Permanent - No expectation for functional improvement

4. For any impairment checked above, please note specific precautions that individual must follow in terms of:

Travel distanct limitations:

Limitations regarding time of day to travel:

Weather conditions:

Environmental conditions:

5. Please choose the statement below which best represents your opinion regarding this individual's use of public transportation:

- This individual should be able to access public transportation successfully.
- This individual can use public transportation under certain situations as stated above.
- This individual cannot use public transportation due to multiple functional limitations.

Signature

Print Name

Print Title

Date Signed

Business Address

Apt/Suite/etc.

City

Zip Code

Phone Number

Organization/Practice

Type of Practice

Thank you for your assistance!