Patient's Name: (please print) _____
Date of Birth: _____ Contact No.: _____
Address: _____

Dear Physician or Healthcare Professional:

We need your assistance in determining eligibility for services provided by METROLift to persons with disabilities who are unable to use local bus transportation. We are seeking specific information as to what prevents the person from using METRORail and the METRO bus routes that provide transportation throughout the area. METRO buses are equipped with ramps, lifts, and kneeling features to assist boarding as well as automatic announcements of major stops to help riders know where they are along the route. The Americans with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states– "..each public entity operating a fixed route system shall provide paratransit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed route system." "By complementary, DOT means service for individuals with disabilities who cannot use the fixed route bus system." The information requested of you in the following sections will be used to help determine the applicant's METROLift eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification. Thank you for your cooperation.

1. Have you previously seen this patient? ◯ Yes ◯ No

2. Please rate (Excellent / Good / Fair / Poor / None / Don't Know) the applicant in terms of:

	Excellent	Good	Fair	Poor	None	Don't Know
a. Upper body strength	◯	◯	◯	◯	◯	◯
b. Lower body strength	◯	◯	◯	◯	◯	◯
c. Coordination	◯	◯	◯	◯	◯	◯
d. Balance	◯	◯	◯	◯	◯	◯
e. Self awareness	◯	◯	◯	◯	◯	◯
f. Independent judgment	◯	◯	◯	◯	◯	◯
g. Sense of direction	◯	◯	◯	◯	◯	◯
h. Ability to understand and follow instructions	◯	◯	◯	◯	◯	◯
i. Verbal communication	◯	◯	◯	◯	◯	◯
j. Written communication	◯	◯	◯	◯	◯	◯
k. Stamina and endurance	◯	◯	◯	◯	◯	◯

3. In your opinion, can the applicant travel independently from his/her house to the sidewalk?
   ◯ Yes ◯ No ◯ Sometimes
   If "no" or "sometimes," please explain. _____

4. Can the applicant walk up and down two steps? ◯ Yes ◯ No ◯ Sometimes

5. Assuming the use of a mobility aid, if applicable, and with no major barriers in his/her path, how far can the applicant independently travel without assistance?
   ◯ less than 1/4 mile ◯ 1/4 mile ◯ 1/2 mile ◯ 3/4 mile ◯ more than 3/4 mile

6. Does the applicant's disability require him/her to travel with another person who provides personal assistance? ◯ Yes ◯ No ◯ Sometimes

7. Please provide medical diagnoses in layman's terms to describe the applicant's primary impairments or disabling conditions.

_____

_____

8. We are seeking specific information as to what prevents your patient from accessing the local bus and rail system.

_____

_____

9. Is the condition ◯ Permanent or ◯ Temporary (months) _____

10. If visually impaired, what is the applicant's best corrected acuity?
(Snellen)? (R) _____ (L) _____
Field Restriction: (R) _____ (L) _____ Date of Testing: _____

11. If cognitively impaired, what is the applicant's cognitive age, and IQ level?

_____

12. Is the applicant a wheelchair user? ◯ Yes ◯ No If yes, how often _____

13. Does the applicant use other mobility aids? ◯ Yes ◯ No If yes, please describe.

_____

_____

PHYSICIAN OR HEALTH CARE PROFESSIONAL'S CERTIFICATION :

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that METROLift may contact me for clarification of any information I have provided and that I will reply in good faith.

Physician's/Health Professional's Full Name _____

Institution/Facility/Agency Name _____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Medical/Social Worker's License Number _____ Telephone # _____ Fax # _____

Physician's/Health Professional's Signature _____ Date _____

***Note: Additional signature of physician/healthcare professional on his/her letterhead or prescription verifying completion of application is required.