



## Part B:

To be completed by Physician or other  
Licensed Health Care Professional  
***Professional Verification of Functional Limitation  
Affecting Mobility for Use in Determining  
ADA Complementary Paratransit Eligibility***

*Dear Licensed Health Care Professional:*

You have been requested by your patient/client to provide information to the MetroWest Regional Transit Authority (MWRTA), regarding his/her disability and its impact on his/her ability to use our transit services. Federal law requires that the MWRTA provide paratransit services to persons who cannot use our fixed route bus service independently.

Please understand that the law is quite strict in defining who is eligible for this specialized service. A person must have an actual physical or mental functional limitation, which prohibits his/her independent use of accessible fixed route public transportation. Just the diagnosis of a potentially limiting illness or condition is not sufficient.

The information that you provide describing the physical and or mental capabilities of this person will allow us to make an appropriate evaluation in keeping with the requirements of the law and the best interests of the applicant. **Please be as specific as possible when describing the disability as well as the limitations due to the disability.** *ALL information on this form will be kept confidential.*

Please return this form, along with the application to: **The MetroWest RIDE, 15 Blandin Ave, Framingham, MA 01702, Attention: ADA Director**, as soon as possible. Processing of this person’s application cannot be completed until we receive this information from you.

*Thank you for your assistance.*

**Please type or print.**

Your name: \_\_\_\_\_

Office address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Phone number: (    ) \_\_\_\_\_

**The application will be returned if all sections are not completed.**



**Patient/client name (please print):** \_\_\_\_\_

1. Capacity in which you know the applicant:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What is the disability or health condition that prevents the applicant from using the fixed bus route?

- Certified Legally Blind
- Loss or inability to use one or more limbs
- Severe effects of stroke
- Paralysis affecting mobility, speech, vision or memory
- Cancer (type) \_\_\_\_\_
- Renal Failure
- Severe Arthritis/Osteoarthritis
- Autoimmune Disorders ie: Lupus or Scleroderma etc.
- Severe cardiac and/or respiratory impairment affecting strength and/or endurance
- Severe emotional disorder (may require an escort)
- Developmental disabilities, ie: mental retardation, cerebral palsy, epilepsy, autism or neurological disorder, etc
- Hearing loss accompanied by an inability to understand speech with/without a hearing aid

Other (please explain): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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3. How does this person's disability limit his/her mobility?

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4. Is the applicant able or unable to perform the following activities?

a. able to climb (3) three, 12 inch steps without assistance?

Able       Unable

If unable please explain: \_\_\_\_\_  
\_\_\_\_\_

b. able to get to/from a bus stop without assistance?

Able       Unable

If unable please explain: \_\_\_\_\_  
\_\_\_\_\_

c. able to board or disembark independently from a Fixed Route Bus?

Able       Unable

If unable please explain: \_\_\_\_\_  
\_\_\_\_\_

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5. Is this condition temporary?

Yes  No

If yes, expected duration.

Condition will last until approximately \_\_\_\_\_, 20\_\_\_\_\_

6. Does this person use a wheelchair or mobility device?

Yes

No

If yes please identify:

\_\_\_\_\_

**If this person has vision impairment, please complete the following:**

7. Visual acuity with best correction:

Right eye\_\_\_\_\_

Left eye\_\_\_\_\_

Both eyes\_\_\_\_\_

8. Visual fields:

Right eye\_\_\_\_\_

Left eye\_\_\_\_\_

Both eyes\_\_\_\_\_

9. Can this person read informational signs?

Yes  No

Can this person navigate independently, despite his/her visual impairment?

Yes  No

If no, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**If this person has a cognitive disability, please complete the following:**

Is he/she able to:

10. Site names, addresses, and telephone numbers upon request? Yes  No

11. Recognize a destination or landmark? Yes  No

12. Deal with unexpected situations or unexpected changes in routine? Yes  No

13. Ask for, understand, and follow directions? Yes  No

14. Safely, effectively and independently travel through crowded and/or complex facilities? Yes  No

15. To your knowledge, does this applicant require the aid of an escort or attendant when they travel? i.e. Personal Care Attendant (*riders must provide their own PCA*)

Yes  No

**16. Please clearly describe any other functional limitation(s) affecting this person's mobility that is not described above.**

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**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**MA License #** \_\_\_\_\_

***The application will be returned if all sections are not completed.***