MetroWest Regional Transit Authority

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,* 37 Waverly Street, 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.

MetroWest Regional Transit Authority

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?

_____

_____

_____

_____

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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MetroWest Regional Transit Authority

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.

_____

_____

_____

_____

Signature _____ **Date** _____

MA License # _____

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