Ben Franklin Transit Dial-A-Ride Professional Certification

** Medical Care Provider Must Complete**

Applicant's Name: _____ **Date of Birth: _____**

The above individual has applied for Americans with Disabilities Act Paratransit (Dial-A-Ride) Services and has listed you as their care provider. Dial-A-Ride is provided for individuals unable to access fixed route buses **due to their disability.** For this reason, your responses in addition to an internal functional assessment will assist us in determining eligibility. As a reminder, all of our fixed route buses are fully accessible (i.e. kneel and have ramps). Travel Training is also offered through our office at no cost for interested individuals.

Diagnosis

Please specify this individual's diagnosis or multiple diagnoses if applicable (provide ICD10 and DSM IV codes):

_____

_____

_____

Permanent? _____ Temporary? _____ /How Long? _____

Is this condition-effected by weather/temperature? If so, specify weather type (hot, cold, both).

Mobility

Do you feel this individual can board a regular bus using the lift, handrails and/or by having the bus lowered to ground level? If not, please explain.

Is walking detrimental to this individual's condition? If so, please explain

If walking is **not detrimental**, how far can is this individual travel doing a combination of walking/standing?

_____***9 blocks*** _____***6 blocks*** _____***3 blocks***

_____***2 blocks*** _____***other (please specify)*** _____

Does this individual use a mobility device? _____No _____Yes

Please specify type of mobility device used: _____

If applicable, how far is this individual able to propel their mobility device without assistance from another individual?

_____***9 blocks*** _____***6 blocks*** _____***3 blocks***

_____***2 blocks*** _____***other (please specify)*** _____

Is a Personal Care Attendant (PCA) necessary for safe travel?

Cognitive/Developmental/Mental Health

Does this disability affect cognitive functions? Please explain.

Is this individual stable or in remission? Yes_____ No_____

If you have a copy of a psychological evaluation from the last three years please provide a copy.

Is this individual capable of recognizing destinations and comprehending what is happening around him/her? If not, please explain.

Is this person capable of using memory aids? If not, please explain.

Is this individual capable of utilizing the bus system with accommodations such as route planning assistance, and announcements of stops when riding? If not, please explain.

Travel Training

Travel Training is a free, self-paced training program for individuals who have the ability to use the regular route buses. Do you feel this individual could benefit from this program?

_____Yes _____No (Please Explain) _____

_____

I am a licensed medical provider or a qualified service provider with a state/county agency in the field indicated below and certify that the above-mentioned individual has the disability and limitations indicated above (RCW (A.72.085 & RCW 40.16.030)**.**

_____ _____

Professional Care Provider's Signature Date

_____

Professional Care Provider's Name **(Please Print)**

_____ _____

Mailing Address Area of Specialization

_____ _____

National Provider Identifier (NPI) **or** Tax ID Number * Phone

*This form considered incomplete without valid NPI or Tax ID Number.