Riverside Transit Agency

HEALTHCARE PROFESSIONAL VERIFICATION

This individual is applying for ADA Dial-A-Ride service. In compliance with the Americans with Disabilities Act (ADA), Riverside Transit Agency provides ADA Priority Service to persons who, due to a disability, are unable to independently use the public fixed route bus system. RTA fixed route buses are equipped with ramps and lifts therefore eliminating the need to negotiate stairs. Public buses offer additional accessibility features like priority seating for seniors and people with disabilities.

All pages of this form must be completed by a licensed healthcare professional in order to complete the application process. The information you provide will allow us to make an appropriate evaluation to determination eligibility of services and its application to specific trip requests. RTA may contact you if further information is required. Thank you for your cooperation.

HEALTHCARE PROFESSIONAL INFORMATION

Please print the following information

Applicant/Patient Name: _____DOB: ___/___/ ___

Healthcare Professional:

First Name: _____ Last Name: _____

Address: _____ Phone: _____

Professional Title: _____Professional License #:_____

I hereby declare under penalty of perjury that the information provided is true and correct.

Signature:_____ Date: ____/____/____

Mail completed form to:

Riverside Transit Agency
Certification Department
P.O. Box 59968
Riverside, CA 92517-1968

Email: adacert@riversidetransit.com

<u>All pages of this form must be completed by a licensed healthcare professional in order to complete the application process</u>.

1. Please describe the applicants condition(s) which affect ability to travel in the community.

Check Relevant Type(s) of Conditions (provide DSM-5 codes)	**LIST SPECIFIC DIAGNOSES**	**Onset Date**	**Prognosis (Expected duration if temporary)**
Physical Disability	**ICD10 code**		
Developmental Disability	**DSM-5 code** **(Circle one)** Mild | Moderate | Severe | Profound		
Cognitive Disability	**DSM-5 code** **(Circle one)** Mild | Moderate | Severe | Profound		
Mental Illness	**DSM-5 code** **(Circle one)** Mild | Moderate | Severe | Profound		
Vision Loss / Blindness	**ICD9 code** Visual Acuity R: _____ L: _____ Totally Blind? Yes___ No___ Legally Blind? Yes ___ No ___ **Is vision corrected with corrective lens? Yes ___ No ___**		
Other _____ Please identify condition:	**DSM-5 code**		

2. Are the applicant's symptoms episodic or variable in their severity?

   □ Yes □ No

   If yes, please explain: _____

3. Does applicant have seizures? □ Yes □ No

   a. Type(s) of seizures? _____

   b. How often do the seizures occur? _____

   c. Are the seizures currently controlled? □ Yes □ No

   d. Is she/he able to function safely and effectively in community? □ Yes □ No

   e. When was the applicant's last seizure? _____

4. Does the applicant take any medication that would complicate the use of public transportation? □ Yes □ No

If yes, please explain _____

a. Do you deem the applicant to be compliant in taking medication? □ Yes □ No

b. Has the applicant's functional ability changed temporarily due to medication adjustment? □ Yes □ No

If yes, please explain and give expected duration: _____

_____

5. Does the applicant's disability prevent them from using the accessible fixed route city bus service? □ Yes □ No

If yes, please explain _____

_____

6. Do you know of any challenges the applicant has with independent mobility?

□ Yes □ No □ Sometimes

If yes or sometimes, please explain _____

_____

7. Does the applicant currently use any of the following mobility devices?

□ None □ Cane □ Scooter/Electric Wheelchair

□ Walker □ Manual Wheelchair □ Portable Oxygen

□ Crutches □ Service Animal □ Communication Board

8. Do you think applicant is able to independently walk / wheel ¾ mile (using a mobility device and brief rest periods if needed)?

□ Yes □ No □ Sometimes

If no or sometimes, please explain_____

_____

9. Does the applicant have a visual impairment that would prevent them from using the fixed route city bus? □ Yes □ No □ Sometimes

If yes or sometimes, please explain _____

a. Is this condition stable, degenerative or otherwise changing?

_____

10. Is the applicant able to independently cross streets?

□ Yes □ No □ Sometimes

If no or sometimes, please explain _____

_____

11. Do any of the following barriers prevent your client/patient from using the fixed route city bus? **(Check all that apply)**

□ Cold	□ Heat	□ Rain
□ Smog	□ Night Blindness	□ Light Sensitivity (bright sun)
□ Hills	□ Lack of sidewalks	□ Rough terrain
□ Unable to transfer buses	□ Lack of strength/ endurance	□ None

12. If the applicant has a **cognitive** disability, which of the following are they **<u>able</u>** to do? (Check all that apply)

- □ Provide address and telephone number
- □ Recognize a destination or landmark
- □ Deal with unexpected situations
- □ Ask for, understand and follow directions
- □ Safely travel through crowded facilities
- □ None of the above

13. Is there any *additional* information you would like to provide regarding the applicant's mobility limitations or functional limitations that would prevent them from using the fixed route city bus? □ Yes □ No

If yes, please explain: _____

_____

_____

_____