Phone: 239-533-0300 **Fax Number : 239-432-2035**

PASSPORT a service of leetran MEDICAL CERTIFICATION FOR PARATRANSIT SERVICE

Part I: This section to be completed by applicant.

Last Name	First Name	Middle Name
Medicaid Number	Date of Birth	Social Security Number
Phone Number	Alternate Phone Number	Email address
Address		

I hereby authorize _____, a licensed Physician, (Work

Phone #)_____ and (Fax #) _____, to release relevant physical and/or mental health information related to my disability, impairment or abilities to travel for the purpose of determining my eligibility for Americans with Disabilities Act (ADA) Paratransit service. I certify under penalty of perjury, that the information in this form and any evidence submitted are true, correct, and to the best of my knowledge.

I understand that this information will be used solely for determining my eligibility for ADA Paratransit service, and that all medical information about my disability will be kept confidential.

Applicant's Signature _____ Date _____

Part II: If you are applying for services due to a medically verified physical or cognitive condition, impairment, or disability; a medical Verification Form must be completed and signed by a licenses medical professional. Accepted Medical Professionals include:

MD, DOM, Chiropractor, OT, PT, Audiologist, RN, LPN, Psychologist, PA, Ophthalmologist.

- In what capacity do you know the patient? _____
- How long have you known or worked with the patient? _____
- Date of your most recent examination of the patient. _____
- Describe/Attach copy of the patient's medical condition. _____
- _____--
- _____--
- The applicant's disability is _____ temporary. …expected duration? _____/_____/_____ Mo. Day Year

  _____ permanent

Last Name	First Name	Middle Name

- Does the patient require Personal Care Attendant (PCA) when traveling on a public vehicle? _____

MOBILITY IMPAIRMENTS

- Can the patient do any of the following without another person:
  - A. Ambulate or walk 1/4 mile (3 blocks)? YES _____ NO _____
  - B. Ambulate or walk 1/2 mile (6 blocks)? YES _____ NO _____
  - C. Ambulate or walk 3/4 mile (9blocks)? YES _____ NO _____

- Can the patient climb 3- 12" steps? YES _____ NO _____
- Ambulate or operate wheelchair up a ramp? YES _____ NO _____
- Can the patient stand and wait for 10 minutes without support? YES _____ NO _____
- Does the patient use any of the following mobility aides? YES _____ NO _____

Manual Wheelchair	_____	Electric Wheelchair	_____	Oxygen	_____
Crutches/Braces	_____	Powered Scooter	_____	Cane	_____
Guide Dog	_____	Walker	_____	None	_____

  - A. Operate a wheelchair 1/4 mile (3 blocks)? YES _____ NO _____
  - B. Operate a wheelchair 1/2 mile (6 blocks)? YES _____ NO _____
  - C. Operate a wheelchair 3/4 mile (9blocks)? YES _____ NO _____
- Can the patient operate wheelchair up a ramp? YES _____ NO _____

VISUAL IMPAIRMENTS **(Provide a copy of a Single Field Analysis for Legal Blindness)**

- Is the patient able to recognize destinations/landmarks? YES _____ NO _____
- Is the patient safely able to cross major intersections? YES _____ NO _____
- Is he/she able to cross streets without help? YES _____ NO _____
- Is the individual able to walk outdoors alone? YES _____ NO _____

Visual Acuity: (with best correction)

Right Eye _____ Left Eye _____ Both Eyes _____

Visual Fields

Right Eye _____ Left Eye _____ Both Eyes _____

What is the formal diagnosis of the applicant's eye disease or condition? _____

- What was the date of onset? _____
- What is the prognosis? Is this conditional stable, degenerative, or otherwise changing?_____
- Where can he/she travel? _____
- Describe the patient's ability to travel outside alone._____

COGNITIVE IMPAIRMENTS

- Is the patient able to give address, phone number? YES _____ NO _____
- Comments about the applicant's stated disability and level of cognitive ability:

_____

- Does the patient travel alone at time?

_____

- What abilities does the applicant have to follow directions to make a trip?

_____

- What abilities does the applicant have to understand time and follow a schedule to get places on time?

Last Name	First Name	Middle Name

_____

- What abilities does the applicant have to know when he/she is lost?

_____

- What ability does the applicant have to cross a street safely?

_____

PSYCHIATRIC DISABILITES

- Describe the prognosis? _____
- Is the patient taking any psychotropic, anti-depressant or other medication(s) prescribed by you?

_____

- If the patient takes his/her medication compliantly, will he/she be able to travel independently in the community?

_____

- Is there anything about the use of medication that would complicate the applicant's use of public transportation? Please explain.

_____

- Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or over friendly)? Please describe.

_____

SEIZURES DISORDERS

- Please describe what the applicant experiences during and after a seizure.

_____

- How often do seizures occur?_____
- What is the prognosis? _____
- Are they preceded by an aura? _____
- What are certain things or circumstances that will trigger the applicant's seizures?

_____

- Please describe the applicant's ability to travel alone in the community. When and where can he/she safely travel?

_____

- Is the applicant taking any medication(s) prescribed by you or another professional?_____
- How the medication(s) may complicate the individual's independent mobility in the community?

_____

- If the patient takes his/her medication prescribed, will he/she be able to travel independently in the community?

_____

- Comments about the applicant's typical activities and current travel destinations.

_____

Last Name	First Name	Middle Name

SUMMARY OF ASSESSMENT

- In your professional opinion, is the patient/passenger capable of traveling alone independently throughout the community? If NO, please explain:

- Is the applicant permitted to drive?

- In your professional opinion, is this person capable of traveling in a fixed route city bus, with little to no assistance? (YES _____ NO _____)

- Please explain why this person is or is not capable of travelling in a fixed route city bus?

- Attached additional relevant medical information. (YES _____ NO _____)

- What is the nature of your medical practice? (e.g., family/general practice, internal medicine, psychiatry, cardiology, etc.)

I am licensed medical professional as described above; I certify that the information on this form and any additional medical information submitted therein are true and correct. Upon consent of the applicant, I agree to release this applicant's relevant medical records upon request from the LeeTran Passport Services.

Physician's Signature _____ **Date** _____

Licensed Physician's Information (type, print or stamp):

Last Name	First Name	Middle Name
Licensed Number	Phone Number	Fax Number
Business Address		