ADA PARATRANSIT

EVALUATION OF FUNCTIONAL ABILITY

To be completed by a health care professional

Cannot be completed by person assisting the applicant with Part A

The COAST ADA paratransit service is point of origin to destination (basically curb to curb) transportation for persons who have a physical or mental impairment (Condition) that precludes them from independently riding the fixed-route bus system. The fixed-route bus system operates on a regular schedule and stops only at designated bus outside their house at or near the requested time and taken directly to their destination.

To qualify, an individual must be unable to use COAST's regular public transit routes due to a specific Condition. Eligibility is a functional determination, not a medical one. Individuals qualify if at least one of the following applies:

1. They have a specific Condition that **prevents** them from independently getting to or from a bus stop safely.

2. They have a specific Condition that **prevents** them from independently identifying the correct bus or destination, boarding or riding the bus, or disembarking at the desired stop.

Instructions

The applicant (or their representative) has completed the TripLink Common Application and has indicated that they have a physical or mental condition that prevents them from independently riding the fixed-route bus system.

The applicant has requested that you complete this Evaluation of Functional Ability. If you are unsure how to answer any of the questions, we suggest that you speak with the applicant or with TripLink. This will help expedite the application process.

Please return the completed Evaluation directly to TripLink. The application must be filled out completely or it will not be processed. The TripLink staff or the COAST Administrative Assistant may contact you to discuss the information you provided.

1. I am familiar with ______________________________’s physical/ mental condition.

☐ Yes

☐ No

☐

2. This applicant’s disability is *(please choose one)*:

☐ **Temporary**
The disability is expected to last between 3 months and one year.

Expected period of disability: ________________________________
(Please be specific, as this information will be used to determine the length of time for which the temporary eligibility card is valid.)

☐ **Long-term**
The disability is expected to last for at least one year, but there is hope of improvement or long periods of remission. All applications based on mental impairments are considered long-term applications.

☐ **Permanent**
The disability will never significantly improve (for example, an amputation or a developmental disability). If the applicant is found eligible, he or she will be automatically issued a new eligibility card every year without the need for re-application.

Please answer the following questions.

A. Is the information about the applicant’s Condition provided in the Common Application complete and accurate?

☐ Yes ☐ No

Comment: ____

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B. Is the information about the applicant’s travel capabilities provided in the Common Application complete and accurate?

☐ Yes ☐ No

Comment: ____

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C. Is the information about the applicant's ability to ride COAST fixed-route buses provided in the Common Application complete and accurate?

☐ Yes ☐ No

Comment: ____

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D. Is there any other reason that the applicant cannot independently and safely get to and from a bus stop, wait a reasonable amount of time, identify and board a regular fixed-route bus, and identify and request the desired stop? (Please note that all COAST buses are equipped with a wheelchair lift or ramp, and major stops are announced.)

☐ Yes ☐ No

Comment: ____

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AUTHORIZED HEALTH CARE PROFESSIONALS

This Evaluation of Functional Ability must be completed by one of the following health care professionals who is familiar with the Applicant's condition:

Must be a Licensed or Certified:

Physician	Physician Assistant
Social Worker	Psychologist
Respiratory Therapist	Physical Therapist
Psychiatrist	Audiologist
Nurse Practitioner	Optometrist /Ophthalmologist
Registered Nurse	Case Manager/Worker
Occupational Therapist	

I hereby certify that the above information is true and accurate to the best of my knowledge.

Signature: ______________________________ Date: ____________________

Print Name: ____

Professional Title: ____

Address: ____

City: ___________________________________State: ______ Zip Code:_____________

Telephone Number: _____________________________________

Fax Number: ____