Community Rides

EVALUATION OF FUNCTIONAL ABILITY

To be completed by a health care professional

Cannot be completed by person assisting the Applicant with Part A

ACT's Community Rides provides free non-emergency medical transportation to older adults (60+) and adults with qualifying disabilities. Clients qualify to use Community Rides if they are 60 or over, have been found 70% disabled by the VA, are Medicare clients, have been found disabled by the Social Security Administration, have been determined to have a server or severe and persistent mental illness, or they have a physical or cognitive condition that prevents them from riding in vehicles that do not have any accessibility features, such as your typical car, truck, or SUV.

Community Rides clients are generally picked up outside their homes at a time that will ensure that they are on time or early for their appointment. This is a shared ride service, so other riders may be on board and the vehicle may make other stops before dropping off the client at their destination.

Eligibility is a functional determination, not a medical one. Individuals qualify if they have a specific Condition that prevents them from riding in a typical automobile.

Instructions

The applicant (or their representative) has completed the TripLink Common Application and has indicated that they have a physical or cognitive condition that prevents them from riding in vehicles that do not have any accessibility features.

The applicant has requested that you complete this Evaluation of Functional Ability. The applicant's Authorization for Release of Medical Information and the completed Common Application are both included with this document. 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 may contact you to discuss the information you provided.

If you have any questions about this form, you may contact TripLink at 603-834-6010 or TripLink@CommunityRides.org

Applicant Name:

Applicant Date of Birth:

1. I am familiar with the applicant's physical/mental condition.

☐ Yes

☐ No

2. The information regarding the applicant's condition and travel capabilities provided in the Common Application is complete and accurate:

☐ 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.

3. In my professional opinion, this applicant is *(please choose one)***:**

☐ **A. Non-Ambulatory Disabled**
The applicant cannot walk, even with the assistance of devices (e.g., walker, crutches, cane, brace, prosthesis, etc.), but has sufficient personal mobility and independence in a wheelchair that the use of fully accessible public transportation is a reasonable expectation.

☐ **B. Semi-Ambulatory Disabled**
The applicant cannot walk more than a very short distance without the assistance of a walker, crutches, cane, brace, prosthesis, or other such adaptive device, and the use of fully accessible public transportation is a reasonable expectation.

☐ **C. Otherwise Disabled from a Transit Perspective**

4. If you chose C for Question 3, please check any of the following that apply to this applicant.

- ☐ Hearing disability (total deafness or hearing loss 90db or greater in the 500, 1000, 2000 Hz ranges despite hearing aids)
- ☐ Vision disability (vision in the better eye is no better than 20/200 after correction, or visual field is contracted)
- ☐ Progressive, debilitating illness that significantly impairs mobility, with chronic symptoms such as pain, fatigue, weakness, or mental status changes (e.g., AIDS, cancer, lupus, etc.)
- ☐ Pulmonary or cardiac disability shown by X-ray, EKG or other tests, and resulting in breathlessness, pain or fatigue despite treatment
- ☐ Faulty coordination from a brain, spinal, or peripheral nerve injury or arthritis
- ☐ Loss or absence of both hands, or loss of major function of both hands
- ☐ Dependency on kidney dialysis to live
- ☐ Cerebrovascular accident (stroke) with persistent physical effects
- ☐ Neurological disability that is not controlled by medication (e.g., epilepsy, multiple sclerosis, etc.)
- ☐ Developmental disability originating before age 22 (e.g., cerebral palsy, autism, Down's syndrome, etc.)
- ☐ Psychiatric disability recognized by the DSM IV and severe enough to cause limitations of daily life functioning
- ☐ Other. *Please attach information about the applicant's diagnosis and its effects relating to the use of public transportation.*

AUTHORIZED HEALTH CARE PROFESSIONALS

The Community Rides 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
- Licensed Social Worker
- Respiratory Therapist
- Psychiatrist
- Nurse Practitioner
- Registered Nurse
- Occupational Therapist
- Physician Assistant
- Psychologist
- Physical Therapist
- Audiologist
- Optometrist/Ophthalmologist
- Case Manager/Worker

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 ______________________