



TRIPLINK COMMON APPLICATION Disability Documentation

Purpose

This evaluation helps TripLink determine if the applicant qualifies for transportation services on the basis of a disability.

Instructions

This Disability Documentation must be completed by one of the following professionals who is familiar with and qualified to speak to the applicant's disability:

Must be a licensed or certified:

Physician
Physician Assistant
Registered Nurse
Nurse Practitioner
Psychologist
Psychiatrist
Mental Health Professional

Audiologist
Optometrist /Ophthalmologist
Physical Therapist
Respiratory Therapist
Occupational Therapist
Social Worker
Case Manager/Worker

1. This form is given to the professional by the applicant.
2. This form must be completed by the professional signing the form, not the applicant.
3. Return the completed evaluation in one of these ways:
 - a. Fax: 855-975-2546 (HIPAA-Compliant)
 - b. Email: TripLink@CommunityRides.org
 - c. Mail: 42 Sumner Dr. Dover, NH 03820

This form must be filled out completely or it will not be processed. TripLink or COAST staff may contact the professional who completed the form to discuss the answers.

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

1. Applicant's Name: _____

2. Applicant's Date of Birth: _____

3. I am familiar enough with the applicant's physical and/or mental disability to answer these questions.

Yes

No

4. Does the applicant have a disability?

Yes

No

5. 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.

6. In my professional opinion, this applicant has *(please choose all that apply):*

- Non-Ambulatory Disability** The applicant cannot walk, even with the assistance of devices (e.g., walker, crutches, cane, brace, prosthesis, etc.)
- Semi-Ambulatory Disability** 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
- 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)
- Pulmonary or cardiac disability** shown by X-ray, EKG or other tests, and resulting in breathlessness, pain or fatigue despite treatment
- 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
- 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
- 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.)
- Other: _____

I hereby certify that I answered the questions above based on my professional judgment (they were not pre-answered by the applicant) and 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: _____