IndyGo[SM]

STEP 2

MEDICAL/PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS FOR OPEN DOOR APPLICANTS

1. Complete the Client Information section below.
2. Send **OR** take this form to one of the following professionals who is familiar with you and your condition(s):

- Physician or Doctor of Chiropractic
- Registered Nurse
- Licensed Social Worker
- Orientation & Mobility Training Specialist
- Nurse Practitioner
- Occupational Therapist
- Psychologist
- Physical Therapist

3. The professional may return this form to you or send it directly to IndyGo's assessment office

CLIENT INFORMATION

Name: ____
First Middle Last

Date of Birth: ________________

Address: ____ Apt. __________

City: ______________________________ State: _______ Zip Code: ________________

Applicant's Phone Numbers: Home: _________________________

Cell: _________________________ Work: _________________________

Client's Signature: ___________________________________ Date: _________________

Guardian's signature is required if the applicant is not his/her own guardian.

Guardian's Signature: _______________________________ Date: ________________

Relationship to client: _______________________________

Dear Health Care Professional:

One of your clients is applying for ADA paratransit service ("Open Door") with the Indianapolis Public Transportation Corporation (IndyGo). ***Your client/patient has authorized you to provide IndyGo Open Door with the medical information needed to determine his/her qualifications for Open Door Services.***

The ADA guidelines are specific with regards to whom and under what circumstances eligibility may be granted. Eligibility is based not only on the presence of a disability or the use of a mobility aid, but on the effects that the disability has on the person's ***functional*** ability to use Fixed Route transit. The accessibility of the Fixed Route service and environmental and architectural barriers ***preventing*** the applicant from traveling to and from any destination in the service area must be considered as well. For some individuals, their disabilities may prohibit them from ***ever*** using the Fixed Route. For others, however, it may be ***conditional*** depending on certain circumstances. A person's age, the inability to drive a car, inconvenience, or discomfort are not qualifying factors.

Please keep in mind the more information you provide regarding your client's abilities and challenges, the better IndyGo can determine eligibility. This Medical/Professional Verification form is one element in making the decision.

Our evaluation is a transportation decision, not a medical authorization.

The disability must PREVENT travel on IndyGo's regular city buses which have the following ACCESSIBLE features:

- All are equipped with wheelchair lifts or ramps, along with securement devices.
- All have kneeling capability, which lowers the height of the first step onto the bus.
- A person does not have to walk up or down bus steps if unable to do so.
- Buses have automated voice announcements alerting passengers to the bus arrival, upcoming stops, and are coordinated with LED signage on board the bus.
- Customer Service and the IndyGo website at www.indygo.net are available to assist with bus schedules and trip planning.

Should you have any questions regarding the assessment process, please call the Open Door Assessment Office at (317) 614-9260. Thank you for your assistance.

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SECTION 1: GENERAL INFORMATION

1. In what capacity do you know the client? ____

2. How long have you known the client? ________________ Date of last visit: ___________

3. Is the client compliant with taking medications? Yes No
If no, would compliance improve the client's functional ability to use transit? Please explain:
____
____

4. Is the client taking any medication that affects their functional ability to travel independently within the community (drowsiness, confusion, etc.)? Yes No
If yes, please explain: ____
____

SECTION 2: INFORMATION ON CLIENT'S DISABILITY

Check Relevant Type(s) of Conditions	List Relevant Diagnoses	Date of Onset	Prognosis (State length of time if temporary)
___ Physical			
___ Vision			
___ Developmental	IQ:		
___ Mental Illness	DSMIV-R code(s):		
___ Cognitive			

Does the individual require a Personal Care Attendant (PCA) when traveling? Yes No

A personal care attendant (PCA) is someone designated or employed specifically to help the eligible individual meet his or her personal needs and is different from a companion or guest. A PCA typically assists with one or more daily life activities such as providing personal care, performing manual tasks, or providing assistance with mobility or communication.

Please complete only the section(s) that apply to the applicant

A. Verification of a Physical Disability

1. Does your client use a mobility aid**?** Yes No (If yes, please check all that apply)
   ___Walking Cane ___Manual Wheelchair ___Walker ___Portable Oxygen
   ___White Cane ___Powered Wheelchair ___Walker with Seat ___Prosthesis
   ___Power scooter ___Extra-Wide Wheelchair ___Service Animal ___Leg Braces
   ___Communication Board ___Other, please specify ____________________________
2. How far do you feel the client could independently propel a wheelchair or ambulate with or without a mobility aid, and without lengthy rest breaks?

   ___Client cannot stand and bear weight without the use of a mobility aid

   ___Half the distance of a football field (150 feet)
   ___The length of a football field (300 feet)
   ___The length of a football field and back (600 feet)
   ___One lap around a track (1,320 feet)

3. With treatment and/or therapy will this distance increase? Yes No

4. Can the client climb (3)12 inch steps? Yes No

5. Client can stand for up to: ____5 minutes ____10 minutes ____15 minutes
   ____20 minutes ____30 minutes ____Cannot stand for any period of time

6. Does the client require a seat to wait for and ride the bus? Yes No

7. Can the client stand on a crowded bus when seats may not be available? Yes No

8. Do weather conditions prevent the client's ability to travel? Yes No
____heat (above 80 degrees) ____cold (below 35 degrees) ____wind
____rain ____snow/ice ____smog
____weather does not affect client's ability to access transportation

9. Does the client have shortness of breath with exertion? Yes No

10. Does the client have seizures? Yes No, If yes, what type of seizure and what is the frequency? ____

Does the client experience auras? Yes No, If yes, do they lose consciousness during a seizure? Yes No

B. Verification of a Visual Impairment/Blindness

1. Please provide the client's visual acuity:

OS: _______________ OD: _____________

Totally Blind? Yes No Legally blind? Yes No

Visual Fields___________________ Depth Perception__________________

2. Is the visual loss permanent? Yes No (If no, please explain): _______________________
____

3. Does the time of day affect the client's ability to travel, due to not being able to see in:

___full daylight ___partial light ____darkness/semi-darkness
___the time of day does not affect client's ability to access transportation

4. Has the client received any Orientation & Mobility (O&M) training? Yes No

5. Is the client able to detect changes on surfaces, see steps or curbs? Yes No

C. Verification of a Hearing Impairment

1. Please describe the hearing impairment and how it prevents the client's functional ability riding a fixed route bus.

____
____
____

2. Does the individual wear hearing aids? Yes No

3. Is the client able to detect environmental cues? Yes No

D. Verification of a Developmental/Cognitive/Mental Impairment

1. Is there a history of brain injury/trauma? Yes No Date of injury: ______________
2. Is the client's judgment impaired? Yes No
3. Is the client's memory affected? Yes No
4. Do they have dementia? Yes No

5. Can the client wait alone at a bus stop, their residence, or places to which they travel? Yes No

6. Does the client experience auditory or visual hallucinations? Yes No

7. Does the client require 24-hour supervision and care? Yes No

8. Does the client have the mental capacity to:

State their name, address, and phone number	Yes	No
Orient to person, place, and time	Yes	No
Process information	Yes	No
Communicate needs	Yes	No
Locate and recognize the correct bus, destination or landmark	Yes	No
Concentrate (attention to task)	Yes	No
Deal with unexpected change(s) in bus routes	Yes	No
Seek and act on directions	Yes	No
Travel safely/effectively through crowds or complex facilities	Yes	No
Signal for a stop when riding a fixed route bus	Yes	No

9. Does the client possess social skills to function successfully in the community? Yes No
If no, please explain: ____
____
____

10. Does the client display behaviors that are unsafe for themselves or others riding transit?
Yes No If yes, please explain: ____
____
____

11. Does the client experience any social anxieties or panic attacks that would interfere with their ability to stand at a bus stop or ride a crowded bus? Yes No
If yes, what triggers the client to experience social anxieties or panic attacks? please explain:
____
____
____

12. Is there any additional information or special circumstances regarding the client which you believe impacts their functional ability to ride public transit?

____
____
____

SECTION 3: AUTHORIZATION

I certify that the information herein is true and correct to the best of my knowledge and ability.

Signature: ____ Date: ___________

Please print your name: ____

Professional title: ____

Professional License, Registration or Certification Number: ______________________________

Clinic/Agency: ____

Address: ____

Phone: _______________________________ Fax: ______________________________

Thank you for your assistance in the completion of this form.

You may mail, fax, or email this form to the IndyGo Open Door Assessment Office or return the form to your client. All forms must be submitted to the Assessment Office before an in-person interview is scheduled.

Mail: IndyGo Open Door Assessments
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Indianapolis, IN 46222

Fax: (317) 614-9316

Email: assessments@indygo.net