

Dear Health Care Professional:

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

The ADA guidelines are specific regarding 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 will also be considered. Their disabilities may prohibit them from ever using the Fixed Route for some individuals. 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 and securement devices.
- All have the kneeling capability, which lowers the height of the first step onto the bus.
- If unable, a person does not have to walk up or down bus steps.
- Buses have automated voice announcements alerting passengers to the bus arrival and upcoming stops and are coordinated with LED signage onboard 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 IndyGo Access Assessment Office at (317) 614-9260. Thank you for your assistance.

[Intentionally left blank]

SECTION 1: GENERAL INFORMATION

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

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

3. Is the client compliant with taking medications? Yes No

If not, 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	The 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 their 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 lengthy rest breaks?

The client cannot stand and bear weight without using 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 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 are unavailable? 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 affects 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 the client's ability to access transportation

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

5. Can the client detect changes on surfaces and 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
To ride 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 where 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 the 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 the social skills to function successfully in the community? YesNo

If not, please explain: _____

10. Does the client display unsafe behaviors 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 impact their functional ability to ride public transit?

SECTION 3: AUTHORIZATION

I certify that the information herein is true and correct to 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 Access Assessment Office or return the form to your client. All documents must be submitted to the Assessment Office before an in-person interview is scheduled.

Mail: IndyGo Access Assessments **Fax:** (317) 614-9316 **Email:** assessments@indygo.net
1501 West Washington Street
Indianapolis, IN 46222

Revised – MedicalVerificationForm – ROTH – 5.31.22