STEP 2

MEDICAL/PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS FOR INDYGO ACCESS 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 their own guardian.

Guardian's Signature: ____________________________________ Date: __________________

Client relationship: ______________________________________

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
2425 West Michigan Street
Indianapolis, IN 46222

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