Client ID:

Mobility Evaluation Form

Name: | DOB:

☐ New Applicant | ☐ Recertification | Date old certification expired:

Applicant Background:

Primary Disability/Medical Condition:

Secondary Disabilities/Medical Condition:

Date of onset:

Prognosis: ☐ Temporary ☐ Permanent ☐ Progressive ☐ Other:

Receiving treatment? ☐ PT ☐ OT ☐ Dialysis ☐ Chemo ☐ Radiation ☐ Other

Comments:

Taking medication? ☐ Yes ☐ No

Medication side effects reported: ☐ Dizziness ☐ Confusion ☐ Fatigue ☐ Other

Comments:

Pain Level: Scale of 1-10 (0 being the worst and 10 the best)

Today: Best Day: Worst Day:

Do the disability effects vary? ☐ Yes ☐ No

Reason for variance: ☐ Exertion ☐ Weather

☐ Other:

Temperature sensitivity? ☐ Yes ☐ No Heat > _____ Cold < _____

Discomfort caused by temperature:

Adverse weather issues? Rain/Snow/Ice/Wind- Reason:

Mobility Aids used: ☐ Yes ☐ No Please list:

Service animal: ☐ Yes ☐ No

Last Bus Ride: Assistance Received: ☐ Yes ☐ No

Comments:

Applicants primary issues with using fixed route:

Assessor: ………………………………………………………………**Date**: …………………

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Client Name: Client ID:

Based upon review of the information obtained from the application process for ADA Paratransit Eligibility certification, Transit Services Division has determined that you are eligible for ADA paratransit transportation services in our area. In accordance with applicable Federal Regulations (49 CFR 37.125 (e)), we are proving you with the following information:

Trip Coding:	Disability Type: A B C D F H M P S V
1. Dangerous Traffic or Pedestrian Situation	Private Info: (ex: ESRD, IDD, CVA, etc.)
2. Trip Requires Transit Transfer	
3. Temporary Weather Conditions- (Specify)	Service Level: ☐ Curb-to-curb (C2C) ☐ Door-to-Door (D2D) ☐ Door-through-Door (DTD) ☐ Do Not Leave Alone (DNLA)
4. Fatigue After Treatment	
5. Terrain or Path of Travel	
6. Not Trained to Destination	
7. When Health Prevents (Good Day/Bad Day)	
8. Non-Accessible Route or Bus Stop	Space Type: AMB WC XW XL SC
9. Out of Town Visitor	Mobility Aids: CN CRU LFT OXY SVC WHT WLK
10. Distance to Bus Stop	
11. Agency/School Will Travel Train	Client ID: Renewal Date:
Denied: ☐ Yes ☐ No Denial Date:	Appeal: ☐ Yes ☐ No
Category: ☐ 1 ☐ 2 ☐ 3 PCA ☐ Yes ☐ No	TAXI ☐ Yes ☐ No
Unconditional: ☐ Yes ☐ No Permanent: ☐ Yes ☐ No	Temporary: ☐ Yes ☐ No

I certify that the above named person is or is not eligible for paratransit services defined by the ADA of 1990:

Signature: Date:

Brief description as to why unable to use FR: (ex: cognitive, unsafe balance, uncontrolled seizures, DM, BP, etc.)