TRANSIT AUTHORITY OF NORTHERN KENTUCKY

MEDICAL / PROFESSIONAL VERIFICATION

TANK's RAMP Service

(Not a request for copies of medical records)

Dear Health Care Professional:

One of your clients has requested an assessment for use of TANK's paratransit service.

We need detailed information about the client's condition or disability that prevents use of the regular bus system. The Americans with Disabilities Act (ADA) is very specific as to whom and under what circumstances eligibility may be granted to use paratransit service. According to the ADA, if a person has the functional ability to use fixed route buses, that person is not eligible for RAMP.

The following factors do not, by themselves, qualify a person for RAMP: disability, distance to and from a bus stop, inability to drive, inconvenience, and/or discomfort.

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

- All are equipped with wheelchair lifts or ramps, along with securing devices.
- All have "kneeling" capability, which lowers the height of the first step onto the bus.
- ALL buses have automatic enunciators that announce major cross streets, when a stop is requested, along with the buses destination.
- Customer service is available to assist with bus schedules and trip routing, including transferring from one bus route to another.
- Travel training service is available to teach passengers how to ride regular city buses.

Should you have additional questions about RAMP, our paratransit service, please call (859) 578-6949

When completed, please fax this form to the TANK Special Service Office at (859) 814-2146 or have the applicant bring it to the assessment.

Applicant's Name: _____ Date of Birth: _____

Address: _____

Phone: _____

1. What was the last date of face to face contact (by you or your agency) with this applicant?

_____

2. Please describe the applicant's condition(s) which affect ability to travel in the community.

Check Relevant Type(s) of Conditions	**List**	**Relevant Diagnoses Date of Onset**	**Prognosis (State length of time if temporary)**
___ Physical Disability			
___Developmental Disability			
___ Cognitive Disability			
___ Mental Illness	DSM IV-TR code(s):		
___ Vision Impairment/ Blindness	Totally blind? Yes __ No__ Legally blind? Yes __ No__		
If other, please identify condition: ___ Other _____			

3. Is the applicant taking medication that affects his or her functional ability to travel independently within the community? (drowsiness, confusion, etc.)? _____Yes _____ No

4. If yes, How does above medication affect applicant's functional ability to travel independently (other than driving) within the community? _____

_____

5. Have the applicant's functional abilities changed temporarily due to adjustment to medication or other factors? Yes ___ No ___ If yes, please explain and give expected duration _____

6. Is disability/condition periodic? Yes ____ No ____

If yes, under what circumstances does disability/condition flare up?

_____

7. Are any of the following affected by applicant's condition(s)? Check ALL that apply:

_____ Orientation
_____ Short term memory
_____ Long term memory
_____ Communication
_____ Gait
_____ Balance
_____ Endurance
_____ Other _____

_____ Problem-solving
_____ Attention
_____ Time management
_____ Judgment
_____ Handling stress
_____ Interacting according to social customs
_____ Impulse Control

8. When using TANK's RAMP transportation services, will the applicant require a personal care attendant? _____ Never _____ Sometimes _____ Always

9. Is there additional information regarding this applicant which you believe impacts his/her functional ability to use TANK's regular city buses or special circumstance which you believe should be considered?

_____

_____

I certify that the information contained herein is true and correct to the best of my knowledge and ability. (To be completed by licensed physician only).

Signature _____ Date _____

Physicians Name _____

Physicians Specialty _____

Professional License Number _____

Practice Name_____

Address _____

Phone _____ Fax _____