



AMERICANS WITH DISABILITIES ACT (ADA)
RIO METRO PASSENGER ELIGIBILITY INFORMATION

THIS FORM IS TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL

Applicant's Name _____

Medical Diagnosis of condition causing disability (optional) _____

Is the Condition Permanent? _____ Yes _____ No

If not permanent, expected duration (date) _____

The following information will be used to ensure that an accurate analysis of the applicant's trip requests can be made by the Rio Metro service.

Does applicant use any of the following aids for mobility? (Check all that apply)

- ___ Cane ___ Power Wheelchair
___ Communication board ___ White Cane
___ Service Animal ___ Walker
___ Power Scooter ___ Portable Oxygen Supply
___ Crutches ___ Manual Wheelchair
___ Personal Care Attendant ___ Leg Braces
___ Picture Board ___ Other type of aid, _____

Can applicant travel without the assistance of another person? ___ Yes ___ No

Can applicant climb three 9-inch steps without assistance? ___ Yes ___ No

Is the applicant on dialysis? ___ Yes ___ No

Does the applicant have a hearing impairment? ___ Yes ___ No

Does the applicant have seizures or spasms? ___ Yes ___ No

Is the applicant able to give address and phone number upon request? ___ Yes ___ No

Is applicant able to recognize a destination or landmark? ___ Yes ___ No

Is the applicant able to deal with unexpected situations or unexpected changes in routine? ___ Yes ___ No

Is the applicant able to ask for, understand and follow directions? ___ Yes ___ No

Can the applicant travel alone through crowded and/or complex facilities? ___ Yes

___ No



If the applicant has a visual impairment:

Visual acuity with best correction:

Right eye _____ Left eye _____ Both eyes _____

Visual fields:

Right eye _____ Left eye _____ Both eyes _____

Please describe any additional information needed to assist this rider: _____

Your professional area of expertise is:

- Physician Audiologist Optometrist
- Psychologist Podiatrist Nurse
- Occupational Therapist Physical Therapist
- Other (please specify) _____

Your Name: _____ Title: _____

Professional License # _____

Agency / Company name: _____

Office Address: _____

Office Phone Number: _____

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

Signature: _____

Date: _____