PART B: Health Care Provider Assessment and Verification

by Citibus - Paratransit

Want to fill this out online instead?
Scan the QR code with your phone's camera
to open a digital version of this form.

Return completed application by mail or by fax (for paper applications only):

- By mail:
  Citibus
  Attn: Citibus Access Eligibility
  P.O. Box 2000
  Lubbock, Texas 79457
- By fax: 806-775-2955

Dear Health Care Professional:

In order to complete this application on behalf of the applicant, you must be a certified or licensed professional.

The applicant is asking you to complete and sign Part B of this form certifying that they have a disability that prevents them from using fixed route bus service. This information will be used to help determine whether or not the applicant needs to use paratransit (curb-to-curb) service or is able to use fixed route service for all or some of their travels. Please make sure to include any supporting documentation that you feel will assist us in making an eligibility determination.

Under the Americans with Disabilities Act (ADA), if a person has the functional and cognitive ability to use Citibus Fixed Route buses, that person is not eligible for paratransit services. Disability alone, distance to and from a bus stop, or the availability of fixed route bus service, is not by itself, a qualifier for paratransit services. Eligibility for other programs is also not a qualifier for paratransit service.

All Citibus fixed route buses are ramp equipped for use by individuals using wheelchairs or by individuals who are not able to use steps.

Who can complete Part B: [must be licensed/certified]

- Physician
- Physician Assistant
- Registered/Licensed Nurse
- Nurse Practitioner
- Podiatrist, Chiropractor
- Optometrist
- Licensed Therapist
- Licensed Social Worker
- Certified O & M Specialist
- Licensed Psychologist
- Licensed Counselor
- Certified Special Education Teacher

I am a: (check all that apply)

Physician Physician Assistant Registered/Licensed Nurse

Nurse Practitioner Podiatrist Chiropractor Optometrist

Licensed Therapist Licensed Social Worker

Certified Orientation & Mobility Specialist Licensed Psychologist

Licensed Counselor Certified Special Education Teacher

Circle all that apply

Other

Optional

To be completed and signed by appropriate health care provider. Please print.

Last Name of the Applicant

Patient/Client's Last Name

First Name of the Applicant

Patient/Client's First Name

When did you begin working with this individual?

- -

Write as YYYY-MM-DD

The applicant has been diagnosed with the following disability(ies):

Physical Cognitive Behavioral/Psychiatric Seizure Disorders

Vision Other

Circle all that apply

If other, please specify:

Optional

Written Medical diagnosis(es) causing disability:

Is the condition permanent?

Yes No

Circle one

If no, what is the expected duration?

Optional

Does this disability prevent the applicant from utilizing the fixed route services (regular bus service)?

Yes No

Circle one

If yes, please describe in detail.

Optional

Does the applicant take medication(s) that have side effects that will significantly reduce or hinder their ability to independently ride the fixed route buses?

No Yes

Circle one

If yes, please explain how the side effects would hinder this applicant's ability to use the accessible fixed route buses:

Optional

The applicant's functional abilities to travel change due to:

Medical Treatments

Environmental Conditions (heat, humidity, cold, ice and snow)

Other factors

None of the above

Circle all that apply

If yes to any of the above, please detail the impact to their ability to travel.

Optional

Can the applicant do the following: (Select all that apply)

Able to wait outdoors for 10 minutes Stand for more than 15 minutes

Ride the fixed routes when feeling well

Ride the fixed routes when not feeling well

Walk or wheel 1/4 mile (3 blocks) without assistance

Circle all that apply

Is the applicant able to be left alone?

Yes No

Circle one

What is the weight (in pounds) of the applicant with their mobility device (if applicable)?

Is the applicant on dialysis?

Yes No

Circle one

Does the applicant have a hearing impairment?

Yes No

Circle one

Please describe any other disability or effect that prevents the applicant from using the accessible fixed route bus service.

Optional

Please provide any other information you believe will help us in making an appropriate eligibility determination.

Optional

Cognitive Disability

What is the formal diagnosis of the applicant's cognitive condition?

Optional

Please specify the applicant's behavioral problems where applicable.

Optional

Is the applicant able to travel alone?

Yes No

Optional • Circle one

Is the applicant able to give addresses and phone numbers upon request?

Yes No

Optional • Circle one

Is the applicant able to recognize a destination or landmark?

Yes No

Optional • Circle one

Is the applicant able to deal with unexpected situations or unexpected changes in routine?

Yes No

Optional • Circle one

Does the applicant have the ability to follow directions?

1-Step Directions 2-Step Directions 3-Step Directions

None of the above

Optional • Circle all that apply

Would the applicant know what to do if he/she became lost while out in the community?

Yes No

Optional • Circle one

If no, explain:

Optional

Does the applicant have the ability to safely cross streets?

Yes No

Optional • Circle one

Please check all that apply to applicant:

Problem Solving Short-term Memory Attention Processing

Foresight/Planning Safety Awareness/Judgment

Optional • Circle all that apply

If any of the above were selected, please specify how these prevent the applicant from being able to safely use the fixed route service?

Optional

Behavioral/ Psychiatric

What is the formal diagnosis of the applicant's condition?

Optional

What is the prognosis for this condition for independent function?

Optional

Has the applicant been prescribed medications for his/her condition?

Yes No

Optional • Circle one

If yes, does this medication allow the applicant to function safely in the community?

Yes No

Optional • Circle one

Does the applicant experience auditory or visual hallucinations?

Yes No

Optional • Circle one

If yes, how do the hallucinations impair the applicant's ability to function in the community?

Optional

Does the applicant have anxiety or panic attacks in closed/crowded spaces?

Yes No

Optional • Circle one

If yes, please explain:

Optional

Are there any life skills that the applicant lacks that would prevent him/her from safely using regular fixed route buses?

Yes No

Optional • Circle one

If yes, please explain in further detail:

Optional

Seizure Disorders

Please specify the type(s) of seizures which afflict the applicant:

Optional

How often do the seizures occur?

Optional

Date of most recent seizure

- -

Optional • Write as YYYY–MM–DD

After a seizure, how long does it take before the applicant is able to function safely?

Optional

What triggers the applicant's seizure?

Optional

Is the applicant taking medication for the seizures?

Yes No

Optional • Circle one

Are the seizures currently controlled?

Yes No

Optional • Circle one

Is applicant able to function safely and effectively in the community?

Yes No

Optional • Circle one

Vision

What is the formal diagnosis of the applicant's vision condition?

Optional

What is the prognosis? Is this condition stable, degenerative or otherwise changing?

Optional

Best corrected Acuity:

Left Eye

Optional

Right Eye

Optional

Both Eyes

Optional

Visual Fields

Left Eye

Optional

Right Eye

Optional

Both Eyes

Optional

Is the individual able to walk outdoors alone?

Yes No

Optional • Circle one

If yes, where can the applicant walk? (select all that apply)

Only on his/her own property and to familiar places

To places nearby (for example, on the same block) To places further away

Optional • Circle all that apply

If the applicant is able to travel outdoors alone, is he/she able to cross streets without help? (Select all that apply)

At quiet streets with very little traffic At traffic lights At busy intersections

With auditory cross signals only Other

Optional • Circle all that apply

If other, please specify:

Optional

Are they able to see steps or curbs?

Yes No

Optional • Circle one

If the applicant is partially sighted:

Is their vision affected by different lighting conditions?

Bright sunlight Dimly lit or shaded places Night Other

Optional • Circle all that apply

If other, please specify those conditions:

Optional

Is the applicant's ability to travel outside alone affected by other conditions?

Yes No

Optional • Circle one • Consider impact of environmental noise and ability to distinguish traffic flow patterns.

If yes, please provide additional detail:

Optional

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

Name of Health Care Provider

License Number/State Issued/Expiration Date (Must be Current)

Specialization

Optional

Office Phone Number

Extension (if applicable)

Optional

Office Street Address

Country/region

First name

Last name

Address

Apartment, suite, etc

City

State

ZIP code

Signature

Printed Name

Date

- -

Write as YYYY-MM-DD