

# Certification of Paratransit Need

for persons with

## Vision Loss/Blindness

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M. I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth      Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_

E-mail Address \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

Phone \_\_\_\_\_

### Vision Loss

Eye Condition

OD \_\_\_\_\_

OS \_\_\_\_\_

Acuity

OD \_\_\_\_\_ Stable or Progressive \_\_\_\_\_

OS \_\_\_\_\_ Stable or Progressive \_\_\_\_\_

## Vision Description

- |  |   |
|--|---|
| <input type="checkbox"/> Totally blind                     | <input type="checkbox"/> Light perception         |
| <input type="checkbox"/> Severely blurred/distorted vision | <input type="checkbox"/> Night blindness          |
| <input type="checkbox"/> Mildly blurred/distorted vision   | <input type="checkbox"/> Severe glare sensitivity |
| <input type="checkbox"/> Central visual field loss         | <input type="checkbox"/> Tunnel vision            |
| <input type="checkbox"/> Half-field loss                   | <input type="checkbox"/> Loss of depth perception |
| <input type="checkbox"/> Color blind                       |   |
| <input type="checkbox"/> Other _____                       |   |

## Mobility Aids

Please circle the aids that you use for mobility:

- |             |                    |                       |           |
|-------------|--------------------|-----------------------|-----------|
| Eyeglasses  | Sunglasses         | White Cane            | Monocular |
| Hearing Aid | Manual Wheel Chair | Motorized Wheel Chair |           |
| Walker      | Crutches           | Support Cane          | Oxygen    |
| Other _____ |                    |                       |           |

Do you use a service animal?    Yes                  No

Type of animal? \_\_\_\_\_

Name of Service Animal School \_\_\_\_\_

Address of Service Animal School \_\_\_\_\_

\_\_\_\_\_

Do you use a Personal Care Attendant?    Yes                  No

## Medical Information

Do you have any other medical conditions besides your vision loss?

Yes                  No

Please list \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies?

Yes                  No

Please list \_\_\_\_\_  
\_\_\_\_\_

Do you use any medications that make you tired, listless or dizzy?

Yes                  No

Please list \_\_\_\_\_  
\_\_\_\_\_

Have you had any accidents or falls?

Yes                  No

Please list \_\_\_\_\_  
\_\_\_\_\_

Do you have any other conditions that affect your travel ability?

Yes                  No

Please list \_\_\_\_\_  
\_\_\_\_\_

## **Orientation and Mobility Training**

Have you received orientation and mobility training?

Yes                  No

If yes,

by whom: \_\_\_\_\_

when: \_\_\_\_\_

where: \_\_\_\_\_

how long: \_\_\_\_\_

information covered \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Basic Mobility Skills**

Can you manage steps and curbs independently?    Yes                  No

Can you read street signs?                                  Yes                  No

Can you distinguish Walk/Don't Walk signs?        Yes                  No

Can you distinguish Red, Yellow, Green?            Yes                  No

Can you cross intersections independently?          Yes                  No

Can you find your way with directions?              Yes                  No

## **Statement of Eligibility**

I, \_\_\_\_\_, am applying for special transport provided by the Americans with Disabilities Act. The information I have provided is true and accurate to the best of my knowledge. I, furthermore, attest that I will use the fixed route bus system when available and that I will only use special paratransit services when the fixed route service is unable to provide transportation to my destination.

\_\_\_\_\_  
Print applicant's name

\_\_\_\_\_  
Applicants signature

\_\_\_\_\_  
Date