Part B: Health Care Provider Certification

All information must be filled out.

Please note the following licensed health care professionals are authorized to fill out the application:

- Physician (MD or DO)
- Psychiatrist
- Physical Therapist
- Registered Nurse
- Ophthalmologist
- Occupational Therapist
- Psychologist
- Optometrist (visual disabilities only)
- Other licensed provider familiar with the applicant's condition

Your patient _____ has requested eligibility for SunDial Paratransit Service. SunDial is an origin to destination, shared ride paratransit service for people whose disabilities or health conditions prevent them from riding the fixed route accessible transportation system all, or part of the time. As the applicant's healthcare provider, you are uniquely qualified to clarify the applicant's **functional abilities and limitations** to ride the SunLine fixed route bus system. In order to determine this applicant's functional abilities, we require you, the healthcare provider, to complete and certify all of the following sections. Please detail how the applicant's disability(ies) or health condition(s) impact his or her ability to board, navigate, and travel independently on the accessible fixed route system. Please be as specific as possible.

The following factors do not, by themselves, qualify a person for paratransit:

- Diagnosis
- Inability to drive
- Age
- Personal finances
- Distance to bus stop
- Inconvenience
- Lack of bus service
- Discomfort

Please be advised that all SunLine buses are equipped with ADA accessible features, such as low floor buses, lifts/ramps, audio announcements, designated priority seating areas for people with disabilities, enhanced signage, kneeling buses, and hand rails.

The information shared will be protected per the requirements identified in the Health Insurance Portability and Accountability Act (HIPAA) and your patient/client has agreed in the release of information. Your patient/client has also authorized the release of further information as needed.

An incomplete application will be returned to the applicant and may delay processing. Every question must be answered and be legible.

Health Care Provider (please print): _____

Institution/Facility/Agency Name: _____

License Number: _____ State Issued: _____

Specialization: _____

Street Address: _____

City/State/Zip: _____

Phone: _____

Email Address: _____

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1. Written diagnosis(es) and ICD-9CM and/or DSM Code(s): _____

_____

2. How long have you been treating the patient? _____
3. When was the last time you saw the patient? _____
4. What is the expected duration of the disability? ◯ Short Term ◯ Long Term
   Short Term: Conditions lasting at least 90 days but are likely to improve within one year
   Long Term: Conditions with absolutely little expectation of improvement
5. In your opinion, does this applicant's disability(ies) prevent him or her from independently using the accessible SunLine fixed route bus service?
   ◯ Yes ◯ No
6. If yes, explain how the disability or health condition impacts the applicant's ability to travel independently on the accessible SunLine fixed route bus system:

_____
_____
_____
_____
_____
_____

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7. Does the applicant require any of the following mobility aids/devices (check all that apply):

☐ Powered/Electric Wheelchair	☐ Manual Wheelchair	☐ Powered Scooter
☐ Walker	☐ Cane	☐ Crutches
☐ Brace	☐ Prosthesis	☐ Portable Oxygen in Cart
Type of Brace: _____	☐ Communication Board	☐ Portable Oxygen in Bag
☐ White Cane	☐ Service Animal	☐ None

☐ Other: _____

8. If this applicant is currently on medication(s), will the side effects significantly reduce or hinder his/her ability to independently ride the accessible SunLine fixed route bus service?

◯ Yes ◯ No ◯ N/A

9. If you selected yes, please explain how the side effects would hinder their ability to use the accessible SunLine fixed route bus service:

_____

_____

_____

_____

For questions 10-22, select Yes (Y), No (N), or Sometimes (S). If you answer Yes or Sometimes to questions 10-22, elaborate on how it prevents the applicant from using accessible SunLine fixed route bus service:

10. Would temperature extremes affect this applicant's ability to ride fixed route bus service? ◯ Y ◯ N ◯ S

Please Explain: _____

11. Would ice and/or snow affect this applicant's ability to ride fixed route bus service transit? ◯ Y ◯ N ◯ S

Please Explain: _____

12. Would poor air quality affect this applicant's ability to ride fixed route bus service? ◯ Y ◯ N ◯ S

Please Explain: _____

13. Does this applicant have any challenges with balance? ◯ Y ◯ N ◯ S

Please Explain: _____

14. Does this applicant have any challenges with memory? ◯ Y ◯ N ◯ S

Please Explain: _____

15. Does this applicant have any challenges with breathing? ◯ Y ◯ N ◯ S

Please Explain: _____

16. Does this applicant have any challenges with strength and endurance? ◯ Y ◯ N ◯ S

Please Explain: _____

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17. Does this applicant have any challenges with ambulating on hills? ◯Y ◯N ◯S
Please Explain: _____

18. Are there any visual impairments that would affect this applicant's ability to ride fixed route bus service? ◯Y ◯N ◯S
Please Explain: _____

19. Are there any hearing impairments that would affect this applicant's ability to ride fixed route bus service? ◯Y ◯N ◯S
Please Explain: _____

20. Does this applicant exhibit any inappropriate social behaviors? ◯Y ◯N ◯S
Please Explain: _____

21. Do you have safety concerns for this applicant in using a bus by themselves? ◯Y ◯N ◯S
Please Explain: _____

22. Does this applicant require a Personal Care Attendant when traveling? ◯Y ◯N ◯S
Please Explain: _____

23. In your medical opinion, what other factors related to the applicant's disability(ies) affect his/her ability to ride the accessible SunLine fixed route service?

_____

_____

_____

_____

_____

_____

_____

I certify that I am legally licensed and am currently treating _____. The above information I have provided hereto is a fair representation of this applicant's disability(ies) or health condition(s) and is true and correct under penalty of perjury according to the laws of the State of California. I understand the information provided will be used for the sole purpose of determining the applicant's eligibility for paratransit service. I also agree that SunLine may contact me for clarification of any information I have provided and that I will reply with good faith. **I understand the information contained herein is true and correct to the best of my knowledge and ability. Any falsification could result in the client's loss of paratransit service.**

Signature: _____ Date: _____