



### Part B: Healthcare Provider Certification

Your patient has requested eligibility for paratransit service. Paratransit service is a shared ride service for people whose disability or health condition prevents them from riding the fixed route system all or part of the time. As the applicant's healthcare provider, you are uniquely qualified to clarify his or her functional abilities and limitations to ride the accessible fixed route service. In order to help us determine this applicant's functional abilities, we require that you complete and certify the following questions. Please detail how the applicant's disability or health condition impacts their ability to travel independently on the accessible fixed route system. Please be as specific as possible. For questions, please call 816-842-9070.

Applicant's Name: ERIC L. NICHOLS

Name of Health Care Provider: \_\_\_\_\_

License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

1. Written Diagnosis: \_\_\_\_\_

2. ICD-9CM Code: \_\_\_\_\_

3. DSM Code: \_\_\_\_\_

4. How long have you worked with this applicant: \_\_\_\_\_

5. Is the disability or health condition: ☐ Temporary ☐ Permanent

a. If temporary, please give the best estimate of recovery time: \_\_\_\_\_

b. If permanent, is disability or health condition progressive: ☐ Yes ☐ No

6. If the applicant has a visual disability, what is their visual acuity in each eye:

Left Eye: \_\_\_\_\_ Right Eye: \_\_\_\_\_

7. How does the applicant's disability or health condition impact their ability to travel independently on the accessible fixed route system?

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8. To your knowledge, does judgment and inhibition impairment prevent the applicant from independently traveling outside the home or immediate environment?

☐ Yes

☐ No

9. To your knowledge, does your client have any short-term or long-term memory problem?

☐ Yes

☐ No

10. Would extremes in temperatures affect the applicant's ability to ride the accessible fixed route system?

☐ Yes

☐ No

11. In your medical opinion, what other factors related to the applicants disability(ies) affect his/her ability to ride the accessible fixed route system?

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I hereby certify that the above information is true and correct.

Signature (*can be electronic*): \_\_\_\_\_

Date: \_\_\_\_\_