Disability Verification Form (DVF)

Medical Assistance Transportation Program
Rural Transportation for Persons with Disabilities (PwD) Program
ADA Complementary Transportation (Freedom Transit)

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. This form is to be completed by a professional who is familiar with the applicant's disability. A professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services to people with disabilities.

Last Name:_____First Name:_____DOB: _____

I understand the purpose of this evaluation is to help determine the most cost effective and appropriate mode of transportation. I understand that the information about the disability contained in this application will be kept confidential and shared only with professionals involved in evaluating eligibility. The below authorization form has been submitted by the above named Applicant, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thank you for your cooperation regarding this matter.

Please answer the following questions (to be completed by the agency or person providing verification of eligibility)

Is the applicant's disability permanent? Yes ☐ No ☐

If not, how long is it expected to last?_____

What is the nature of the applicant's disability? Check those that apply.

- ☐ Mobility disability (please see question to the right)
- ☐ Vision disability
- ☐ Hearing disability
- ☐ Cognitive disability
- ☐ Mental disability
- ☐ Other Please specify:_____

Please check all mobility aids that apply.

- ☐ Manual Wheelchair
- ☐ Power Wheelchair
- ☐ Motorized Scooter
- ☐ Crutches
- ☐ Cane
- ☐ Walker

Does the applicant require a Personal Care Attendant (PCA)? (Circle one) YES ☐ NO ☐

Medical Diagnosis of Condition Causing Disability: _____

Please respond to all of the following:

Indicate the ease in which the applicant can complete the task below related to using public transit.	Always	Usually	Occasionally	Rarely	Permanent	Temporary
Recognize a bus stop, Identify bus and route #	☐	☐	☐	☐	☐	☐
Understand bus fare or monetary transactions	☐	☐	☐	☐	☐	☐
Recognizing destinations when stops are announced	☐	☐	☐	☐	☐	☐
Provide addresses and telephone numbers upon request	☐	☐	☐	☐	☐	☐
Safely/effectively travel through crowded/complex facilities	☐	☐	☐	☐	☐	☐
Deal with unexpected situations or change in routine	☐	☐	☐	☐	☐	☐
Understand or handle emergencies well	☐	☐	☐	☐	☐	☐
Communicate with people	☐	☐	☐	☐	☐	☐
Ask for, understand, and follow directions	☐	☐	☐	☐	☐	☐

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Indicate the ease in which the applicant can complete the task below related to using public transit.	Always	Usually	Occasionally	Rarely	Permanent	Temporary
Able to wait outside without support for 10 minutes	☐	☐	☐	☐	☐	☐
Waiting up to 1 hour	☐	☐	☐	☐	☐	☐
Navigate/travel less than a 1/4 mile	☐	☐	☐	☐	☐	☐
Navigate/travel less than 3/4 mile	☐	☐	☐	☐	☐	☐
Mobility up to 3 - 12 inch steps without assistance	☐	☐	☐	☐	☐	☐
Independent use of mobility ramp	☐	☐	☐	☐	☐	☐
Use of lift equipment with assistance	☐	☐	☐	☐	☐	☐
Other (describe)	☐	☐	☐	☐	☐	☐

Is there any other affect of the disability that should be made known? Please specify: _____

_____

_____

Due to the disability indicated herein, I hereby certify that the above-named applicant is unable to utilize the fixed route bus service including mass transit facilities as effectively as persons who are not so affected, and to the best of my knowledge the above information is true and correct. In signing, I acknowledge that to the best of my knowledge, the information in this evaluation form is true and correct. Furthermore, I certify that I have medical information on file to document the above statements and will produce such documentation at the request of the Transportation Provider. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

_____

Print Name of Person Signing Signature PA License # Date

_____

Office Street Address City, State, Zip Phone Number

**If you should have any questions concerning the above information, please contact Freedom Transit, 724-223-8747.*

**Please return form via email to info@freedom-transit.org, or fax 724-223-9474, or mail to Freedom Transit, 50 E. Chestnut St, Washington, PA 15301.*