



CITY OF EVANSVILLE
Metropolitan Evansville Transit System

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Todd M Robertson
Executive Director

LLOYD WINNECKE
Mayor

Jonathan M. Siebeking
Director

Medical Documentation Form

THIS SECTION MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN, NURSE, OCCUPATIONAL OR PHYSICAL THERAPIST, QUALIFIED MENTAL HEALTH PROFESSIONAL, INDEPENDENT LIVING SPECIALIST, REHABILITATION COUNSELOR, OR OTHER PROFESSIONAL FAMILIAR WITH YOU AND YOUR DISABILITY

The attached application has been submitted by (Client's Name): _____
who has indicated that you are familiar with his/her disability. **The purpose of this form is not to verify the applicant's medical condition, but to verify the effect of his/her medical condition on the ability to get around independently. All questions must be answered for this form to be considered complete.**

This information will allow **METS (Metropolitan Evansville Transit System)** to make a fair evaluation of the applicant's request for Paratransit Services.

Thank you for your cooperation.

1. Capacity in which you know the applicant: _____

How does the disability cause a functional limitation that affects this person's ability to get around on his/her own? If the person's ability to get around on his/her own varies in degree at different times, explain the worst case scenario. Please be specific.

2. Is this condition temporary? ____ Yes ____ No

If Yes, expected duration until: _____

3. If the applicant has a disability affecting mobility, answer the following:

a. Assuming the length of a city block is 500 feet, how many blocks can this person walk without assistance?

___ 0 Blocks ___ 1 Blocks ___ 2 Blocks ___ 3 Blocks ___ 4 Blocks
___ 5 Blocks ___ 6 Blocks ___ 7 Blocks ___ 8 Blocks ___ 9 Blocks

b. Does this person use mobility device(s)? ___ Yes ___ No **If Yes, what type (s)?**

___ Manual Wheelchair ___ Electric Wheelchair ___ Power scooter ___ Crutches
___ Cane ___ Walker ___ Prosthesis ___ Brace
___ White Cane ___ Service animal ___ Attendant
___ Other: _____

c. With the use of a mobility device, how many blocks can the applicant travel independently?

___ 0 Blocks ___ 1 Blocks ___ 2 Blocks ___ 3 Blocks ___ 4 Blocks
___ 5 Blocks ___ 6 Blocks ___ 7 Blocks ___ 8 Blocks ___ 9 Blocks

d. How many 7-inch steps (avg. step height) can this person climb without assistance?

e. How many 10-inch steps can this person climb without assistance? _____

f. How long do the person have the ability to wait for a bus at a bus stop?

___ 10 minutes ___ 15 minutes ___ 30 minutes Other: _____

g. Is the individual able to independently maneuver onto and off of a wheelchair lift with or without a mobility aid? ___ Yes ___ No

h. Does this individual require a Personal Attendant/PCA when traveling on public transit?

___ Yes ___ No

i. Can this individual read informational signs? ___ Yes ___ No

If No, please explain: _____

j. Can this individual navigate independently? ____Yes ____No

If No, please explain: _____

IS THIS PERSON ABLE TO:

k. Give his/her address and telephone number on request? ____Yes ____No

l. Recognize landmarks while riding a moving vehicle? ____Yes ____No

m. Deal with unexpected situations or unexpected changes in routine? ____Yes ____No

n. Ask for, understand and follow directions? ____Yes ____No

o. Safely/effectively travel through complex and/or crowded facilities? ____Yes ____No

4. If any, what specific weather conditions prevent the individual from getting around on his or her own? Please explain completely: _____

5. Please describe any other functional limitation(s) affecting mobility not described above. Be Specific:

6. Your Name and Title: _____

Office Address: _____ **Off. Phone:** _____

Signature: _____ **Date:** _____