Dear Health Care Professional:

The Americans with Disabilities Act of 1990 (ADA) is a civil rights law which bans discrimination against people with disabilities. To meet their needs, public bus companies must provide a variety of services.

You have been requested by your patient/client to provide information to the Greater Attleboro-Taunton Regional Transit Authority (GATRA) regarding his/her ability to use our transit services. Federal law requires that the Greater Attleboro-Taunton Regional Transit Authority (GATRA) provide paratransit service (Dial-A-Ride) to persons who cannot use our fixed-route bus service.

Please understand that the law is quite strict in defining who is eligible for this specialized service. A person must have an actual physical or mental functional limitation which prohibits their use of accessible fixed-route public transportation.

The information that you provide describing the physical and mental capabilities of this person allows us to make an appropriate evaluation of his/her application in keeping with the requirements of the law and the best interests of the applicant. All information on this form will be kept confidential.

The processing of this person's application cannot be completed until we receive this information from you. Thank you for your assistance.
How does this person's disability or disabilities cause functional limitations that adversely affect his/her mobility?

Is this condition ___________ Permanent
Temporary ___________ Expected duration is ____________________ months
Can applicant climb stairs?  _____Yes  _____No
Read Survival Signs?  _____Yes  _____No
Hear Spoken Directions?  _____Yes  _____No
Is applicant able to take the regular fixed-route bus service? (All of GATRA's buses are wheelchair accessible.)  _____Yes  _____No  _____Sometimes

Explanation:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
If applicant has a vision impairment, please complete the following:

Vision Acuity with best correction:
Right Eye  Left Eye  Both Eyes

Visual Fields:
Right Eye  Left Eye  Both Eyes

Can the applicant read informational signs?  ____Yes  ____No

Able to cross busy streets and intersections?  ____Yes  ____No

Is applicant able to use regular fixed-route bus service despite his/her visual impairment?

____Yes  ____No  ____Sometimes

If no or sometimes, please explain:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

If this person has a cognitive disability, please complete the following:

Is he/she able to:

Give their name, address and telephone number upon request?  ____Yes  ____No
Recognize a destination or landmark?  ____Yes  ____No
Deal with unexpected situations or unexpected changes in routine?  ____Yes  ____No
Ask for, understand and follow directions?  ____Yes  ____No
Safely and effectively travel through crowded and/or complex facilities?  ____Yes  ____No

Please describe any other functional limitation(s) affecting this person's mobility that are not described above:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

IMPORTANT — SEE BACK PAGE!
PROFESSIONAL CERTIFICATION AND VERIFICATION

I certify that this information is correct to the best of my knowledge.

DATE: ____________________________

PROFESSIONAL SIGNATURE: ____________________________

LICENSED MASS I.D. NUMBER: ____________________________

PHONE: ____________________________

PATIENT NAME: ____________________________

Please mail completed form to:

GATRA
2 Oak Street
Taunton, MA 02780
Attn: Joan Gallagher