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Phone: 503-361-7554
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Office Use Only – Date Stamp

Medical Professional Questionnaire for Cherriots LIFT/Paratransit Eligibility

Part 2 – To be filled out by your Medical Professional*

Dear _____, Date: _____
(Medical Professional)

I, _____, have asked Cherriots LIFT to determine my
(Applicant's Name)
eligibility to use their Cherriots Local city bus service or their paratransit service. **Please respond to the following questionnaire and mail or fax the completed form.**

HIPAA Statement: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care treatment from you, however it may impact the ability of Cherriots to determine my eligibility for paratransit services. I understand that I may cancel this authorization in writing at any time. The cancellation will not affect any information that you disclosed prior to cancellation. This authorization will expire one year from the date of this letter. I understand that the information released may be subject to re-disclosure and no longer protected under federal and state law.

_____ _____
Signature of Patient or Legal Representative Contact Number

_____
Relationship to Patient (if applicable)

If I revoke this authorization, I will send a written request with a copy of this form to you at the address above.

**Medical professional for this form is defined as an MD, DO, PA, NP, RN, OT, or PT*

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First Name: _____ Last Name: _____ DOB: _____

What is Cherriots LIFT/ADA Paratransit and Who is Eligible?

Cherriots LIFT is the Americans with Disabilities Act (ADA) complementary paratransit service for the Salem-Keizer area. Cherriots LIFT is an origin to destination, shared ride, public transportation service for individuals with disabilities who are unable to use Cherriots Local city bus service due to significant functional limitations. The following features of the Cherriots Local city bus system allow many individuals with disabilities to use these routes:

- Cherriots Local city buses are equipped with ramps and a lower step function-kneeling (climbing steps are no longer necessary to ride Cherriots buses)
- Announcement system that identifies major bus stops and transfers
- Internal and external reader signs which provide a visual que for riders with hearing impairment
- Priority seating: a dedicated area for seniors and people with disabilities
- Bus stop improvements including curb ramps at intersections and adding benches and shelters at many locations

Please Note: Paratransit eligibility is not based on age, inability to drive, or the lack of availability or inconvenience of Cherriots Local city bus service.

This Medical Professional Questionnaire, in conjunction with an interview and functional assessment, will be used to help determine what Cherriots service best meets the applicant's needs.

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1. Capacity in which you know this applicant: _____

2. Does the applicant use any of the following devices to assist with their mobility needs?

☐ Cane	☐ Prosthetic Device	☐ Power Scooter	☐ Picture Board
☐ White Cane	☐ Manual wheelchair	☐ Portable Oxygen	☐ Service Animal
☐ Crutches	☐ Power Wheelchair	☐ Alphabet Board	☐ Walker

☐ Other: _____

First Name: _____ Last Name: _____ DOB: _____

3. What health related condition(s) or diagnosis makes it difficult or prevents the applicant from using Cherriots Local (regular city) buses?

_____

_____

_____

4. Please indicate by marking yes, no, or not sure, if your patient does/does not have **"Functional Limitation(s)"** that may make it difficult or prevents them from using Cherriots Local (regular city) buses?

PHYSICAL ABILITIES: Patient is within normal limits for:	Yes	No	Not Sure
Walking speed – *is not unusually fast or slow*	☐	☐	☐
Walking distance - *is able to ambulate 1/4 mile*	☐	☐	☐
Endurance – *is able to safely and independently complete a bus trip*	☐	☐	☐
Coordination and balance – *is stable, does not present a fall risk*	☐	☐	☐
Strength – *is strong enough for safe, independent travel*	☐	☐	☐
Gait – *is normal, without hindrance or disturbance affecting travel*	☐	☐	☐
Range of Motion – *doesn't present ambulation difficulties affecting travel*	☐	☐	☐
Dexterity – *does not present ambulation difficulties affecting travel*	☐	☐	☐
Climbing Steps – *can the patient independently climb three 12" steps?*	☐	☐	☐
Waiting Outside – *can patient wait independently outside for 10 min.?*	☐	☐	☐
Mobility Aids – *is the patient proficient in using their mobility aids?*	☐	☐	☐

SENSORY FUNCTIONS: Is the patient:	Yes	No	Not Sure
Oriented and aware of their personal space?	☐	☐	☐
Able to detect changes on surfaces *(tactile)?*	☐	☐	☐
Able to detect environmental cues *(seeing, hearing, feeling)?*	☐	☐	☐
Visual Acuity with best correction: *(if information is available)* Right Eye: _____ Left Eye: _____ Both Eyes: _____ Visual Fields: Right Eye: _____ Left Eye: _____ Both Eyes: _____			

First Name: _____ Last Name: _____ DOB: _____

COGNITIVE ABILITIES: Does the patient possess:	Yes	No	Not Sure
Orientation skills – *ability to orient oneself to person/place/thing?*	☐	☐	☐
Judgment/safety skills - *adequate for safe, independent travel?*	☐	☐	☐
Problem solving skills - *adequate for safe, independent travel?*	☐	☐	☐
Coping skills - *adequate for safe, independent travel?*	☐	☐	☐
Short-term memory - *adequate for safe, independent travel?*	☐	☐	☐
Long-term memory - *adequate for safe, independent travel?*	☐	☐	☐
Attention to task - *adequate for safe, independent travel?*	☐	☐	☐
Public behavior - *able to maintain appropriate behavior in public setting?*	☐	☐	☐
Way-finding skills - *adequate for safe, independent travel?*	☐	☐	☐
Communication skills - *adequate for safe, independent travel?*	☐	☐	☐
Ability to recognize and respond to dangerous situations?	☐	☐	☐
Ability to deal with unexpected situations or changes without assistance?	☐	☐	☐
Ability to state street address and telephone number upon request?	☐	☐	☐
Ability to recognize destination or landmarks?	☐	☐	☐
Ability to ask for, understand, and follow directions?	☐	☐	☐
Ability to safely and effectively travel through crowded or complex facilities?	☐	☐	☐

5. Are these functional limitations ☐ permanent or ☐ temporary

   If temporary, for how long? _____

Signature of Health Care Provider: _____

Print Name of Health Care Provider*: _____

Date: _____ Phone: _____

Office Address: _____

_____

**Health Care Provider for this form is defined as an MD, DO, PA, NP, RN, OT, PT*

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