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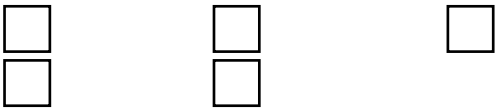

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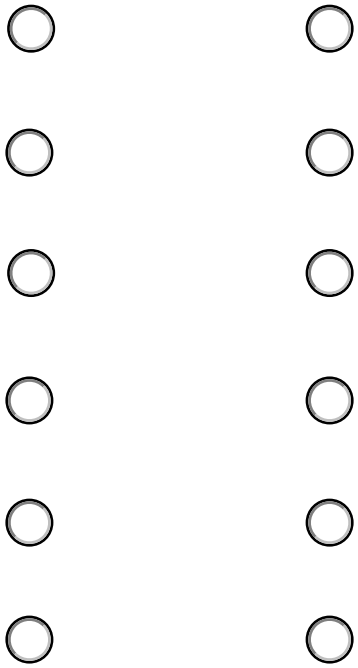

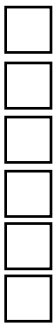

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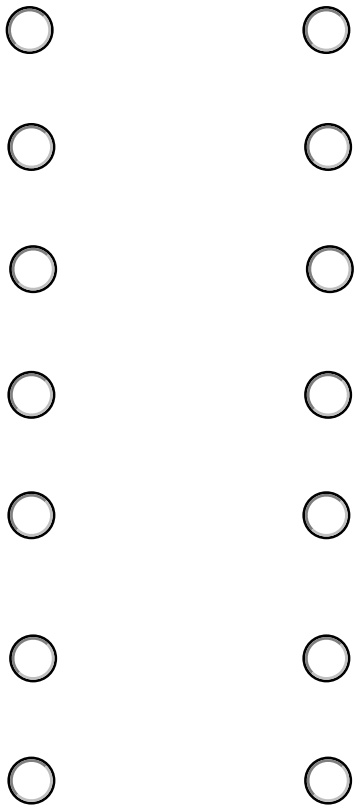

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Incomplete applications will be returned to the applicant

Part B

Healthcare Professional Verification

This section must be completed by a licensed health care or rehabilitation professional familiar with your disability or medical condition and your functional abilities.

Patient Information	
Patient Printed Name:	
Patient Date of Birth (mm/dd/yyyy):	
Patient Address:	
Patient Phone:	
(Passenger ID# Internal Use Only)	

In accordance with: The Americans with Disabilities Act (ADA) of 1990, 49 CFR 37.121, Subpart F, you are being asked by the applicant in Part A and above of this application to provide information regarding his/her abilities to use the Charlotte Area Transit Systems (CATS) fixed route transit service. CATS may provide ADA Paratransit services to individuals who have a disability or medical condition that prevents him/her from sometimes or always using the fixed route bus or rail system. The inability to used fixed route bus or rail service may include being unable to travel to or from bus/rail stops, board or exit buses/rail cars or understand how to ride and use the transit system. The information you provide will allow us CATS to evaluate the request and determine this individual's specific needs. Thank you for your cooperation.

Please note: The CATS fixed route bus and rail system is accessible to persons with disabilities who need ramps to board and exit buses/ rail cars, vehicles which kneel to the curb, and/or need audio announcements of transit stops. The individual applying for ADA paratransit **must be unable to access these services** due to:

- Conditions which prevent him/her from getting to or from a CATS fixed route bus stop, or transferring between vehicles and/or
- Conditions which prevent him/her from being able to get on, ride, or get off a bus with a ramp.

Individuals for whom performing these tasks is inconvenient or uncomfortable are **Not Eligible** for paratransit services, and you are asked to verify this.

1. Please read Part A of this application in its entirety.
2. Fill out Part B of the application completely, using the criteria provided.
3. Return the application to the applicant

4. You may be contacted for additional information if questions remain about the applicant's abilities.

If you have any questions, contact CATS at (704) 336-5055.

Healthcare Professional Attestation				
I have read **PART A** in its entirety:	◯ Yes ◯ No			
I have seen this applicant previously:	◯ Yes ◯ No			
If No explain:				
Date I last saw or treated the applicant?				
Applicant's disabling condition(s) in layman's terms:				
If cognitively impaired, what is their cognitive age and IQ level?				
In my opinion, the applicant can travel independently from his/her house to the sidewalk:				
◯ Yes ◯ No ◯ Sometimes *If No or Sometimes please explain:*				
List any mobility aids used by the applicant:				
Assuming the use of a mobility aid, if applicable, and with no major barriers in their path, how far can the applicant independently travel without assistance? Up to:				
☐ < 1/4 mile ☐ 1/4 mile ☐ 1/2 mile ☐ 3/4 mile ☐ > 3/4 mile				
If visually impaired, list their best corrected acuity				
Snellen:	R:	L:		
Field Restriction:	R:	L:	Date tested:	
Does the applicant's ability to travel change due to medical treatments, environmental conditions (heat, humidity, cold, snow and ice) or other related factors?				
◯ Yes ◯ No ◯ Sometimes *If Yes or Sometimes please explain:*				
Their conditions are	◯ Permanent ◯ Temporary (months) _____			

CATS
SOLICITUD DE ELEGIBILIDAD DE ADA

Additional Comments:	

Please initial the statement below that best represents your opinion regarding this individual's use of public transportation:	
	This individual should be able to access the fixed-route bus services successfully.
	This individual cannot use the fixed-route bus service due to multiple functional limitations.
	This individual can use the fixed-route bus service under certain situations as stated below:

I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that CATS may contact me for clarification of any information I have provided and that I will reply in good faith.

Health Professional's Full Name (Print)			
Company or Agency			
Address			
License, or Certificate #			
Phone		Fax	

Completion of this application by any other profession will not be accepted. Professional affiliation (Check the appropriate designation):

☐ Licensed Physician	☐ Licensed Physical Therapist	☐ Licensed Occupational Therapist
☐ Certified Social Worker	☐ Certified Orientation/ Mobility Specialist	☐ Certified Psychologist/ Psychiatrist
☐ Certified Rehabilitation Counselor	☐ Other: _____	

Signature:		Date:	

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