Americans with Disabilities (ADA)
Professional Verification Form

To Be Completed by the Applicant

I, ___________________________________ authorize the professional completing the
(Printed Name of Applicant)
Professional Verification Form to release to Apple Country Public Transit and WNCSource any protected health information about my disability/health condition in order to verify of my eligibility for ADA Paratransit service.

Signature: _______________________________________ Date: ____/____/____

To the Applicant:

Please have this form completed by a professional before sending your application to ACPT. Any one of the following professionals listed below may fill out and sign this Professional Verification form:

To the Professional:

Please check your professional title

- ○ Physician
- ○ Psychiatrist
- ○ Chiropractor
- ○ Certified orientation & Mobility Specialist
- ○ Physician's Assistant
- ○ Nurse Practitioner
- ○ Registered Nurse
- ○ Physical Therapist

Greetings,

This is the Professional Verification Form for Apple Country Public Transit (ACPT) ADA Paratransit. The ADA regulations state that persons are eligible for ADA Paratransit service, if their pick-up and drop-off points are in the ¾ mile buffer zone and have a condition that prevents them from independently using ACPT Fixed Route Bus Service. ADA Paratransit eligibility is not based on the person's lack of knowledge of the bus service, distance from bus service, ability to drive, language ability, or age. The information you provide will assist in determining under what circumstances this applicant may be eligible for ACPT ADA Paratransit Service.

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1. Applicant's Name: ____
2. Applicant's DOB: ____
3. Capacity in which you know the applicant: ____________________________

   ____
4. Last date of face-to-face contact with this applicant was on: _________________
5. Please describe the condition that may prevent the applicant from independently using the ACPT Fixed Route Bus system:____________________________________

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6. Would the condition prevent the applicant from using the ACPT Fixed Route Bus Route some or all the time? Please Explain.________________________________

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7. Is the applicant's condition:

   ○ Temporary ○ Permanent
8. If temporary how long would you anticipate the condition lasting?

   ○ 4 months ○ 9 months ○ Other:

   ○ 6 months ○ 12 months _________

Does the applicant have the mental capacity, visual, and/or hearing ability to:

9. Ask for, understand, and follow directions?

   ○ Yes ○ No
10. Safely/effectively transfer to another bus if needed?

   ○ Yes ○ No

11. Are there any other mobility concerns of which ACPT should be aware? If so please explain: ____

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Can the applicant complete the following on their own or with the aid of a mobility device?

12. Travel less than a block (approx. 200ft)?

○ Yes ○ No

13. Step up on to and off a curb?

○ Yes ○ No

14. Grip a hand rail?

○ Yes ○ No

15. Does the applicant use a mobility device(s)? Please check all that apply.

○ Support Cane
○ White Cane
○ Walker (collapsible)
○ Walker (with seat)
○ Wheelchair (manual)
○ Wheelchair (reclining)
○ Power Chair
○ Scooter
○ Crutches
○ Leg Brace(s)
○ Charcot Boot
○ Portable Oxygen Device
○ Hearing Aide(s)
○ Prosthesis
○ Other Device

Please describe "Other Device" if selected: ______________________________

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16. Does the applicant require a Personal Care Attendant (PCA) to travel? Please explain:

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17. Are there any other comments you would like to include about the applicant in regard to their condition? ____

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____

I, certify under penalty of perjury that the information contained in this form is true and correct.

Name: ____ Position/Title: ____________________

Signature: ____ Date: ____/____/____

Name of Organization/Office: ____

Address: ____

Phone: ________________________________ Email: __________________________________

Instructions for Submitting This Form:

If the applicant requests you return this form to them, please return it to the applicant in an official sealed envelope. You may also submit the form via the following methods:
Mail: Apple Country Public Transit c/o WNCSource, PO Box 685, Hendersonville, NC 28793
Email: bwilson@wncsource.org
Fax: (828) 692-0685