555 Court St NE, Suite 5230
Salem, OR 97301-3980
Phone: 503-588-2424
Fax: 503-361-7560

Office Use Only – Date Stamp

QUESTIONNAIRE FOR TRANSIT ELIGIBILITY

To be filled out by your **Medical Professional**

Date: _____

Dear _____:
Medical Professional

I, _____, have asked the Salem-Keizer Transit District to
Applicant's Name
determine my eligibility to use their fixed route 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 Salem-Keizer Transit District 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 (If applicable) Relationship to Patient

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

Rev. 7/2015

First Name: _____ Last Name: _____ DOB: _____

What is CherryLift and Who is Eligible?

CherryLift is the Americans with Disabilities Act (ADA) Paratransit transportation service for the Salem-Keizer area. CherryLift is an origin to destination, shared ride public transportation service for individuals with disabilities who are unable to use Cherriots fixed route service due to significant functional limitations.

Eligibility is not based on your age, inability to drive or the lack of availability or inconvenience of fixed-route service.

The CherryLift Evaluation will be used to determine what Cherriots services best meets the applicant's needs. The following features of our fixed route system will allow many individuals with disabilities to use Cherriots fixed routes.

- Cherriots buses are equipped with lifts and a lower step function (kneeling)
- Announcement system that identifies major bus stops and transfers
- Cherriots buses provide a priority seating area for seniors and people with disabilities
- Bus stop improvements include curb ramps at intersections as well as benches and shelters at many locations

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1. Capacity in which you know this applicant: _____

2. What functional limitation(s) or health-related condition(s) make it difficult or prevents the applicant from using Cherriots fixed route buses?

_____

_____

_____

_____

_____

3. Does the applicant use any mobility devices?

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

4. Can the applicant independently ambulate 200 feet (with or without a mobility device)?

☐ Yes ☐ No ☐ Sometimes

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5. Can the applicant independently ambulate ¼ mile / 3 blocks (with or without a mobility device)?
   ☐ Yes ☐ No ☐ Sometimes

6. Can the applicant independently climb three 12 inch steps?
   ☐ Yes ☐ No ☐ Sometimes

7. Can the applicant wait outside independently for 10 minutes?
   ☐ Yes ☐ No ☐ Sometimes ☐ With a mobility device

8. Visual acuity with best correction:
   Right Eye: _____ Left Eye: _____ Both Eyes: _____

9. Visual Fields:
   Right Eye: _____ Left Eye: _____ Both Eyes: _____

10. Is the applicant able to state address and telephone numbers on request?
    ☐ Yes ☐ No ☐ Sometimes Why? _____

11. Is the applicant able to recognize destinations or landmarks?
    ☐ Yes ☐ No ☐ Sometimes Why? _____

12. Is the applicant able to deal with unexpected situations or unexpected changes in routines?
    ☐ Yes ☐ No ☐ Sometimes Why? _____

13. Is the applicant able to ask for, understand and follow directions?
    ☐ Yes ☐ No ☐ Sometimes Why? _____

14. Is the applicant able to safely and effectively travel through crowded and/or complex facilities?
    ☐ Yes ☐ No ☐ Sometimes Why? _____

15. Are these functional limitations ☐ permanent or ☐ temporary?
    If temporary, how long? _____

Signature of Health Care Provider: _____

Print Name of Health Care Provider: _____

Date: _____ Phone: _____

Office Address: _____