555 Court St NE, Suite 5230
Salem, OR 97301-3980
Phone: 503-361-7554
Fax: 503-361-7560

Office Use Only – Date Stamp

CherryLift/ADA Paratransit Service Application

Part 1 – General Information, to be completed by applicant

It is important to complete all parts of this form.
Evaluations that are not fully completed or legibly written will be returned.

This application is for ☐ New eligibility ☐ Recertification ☐ Temporary eligibility

First Name: _____ Middle Initial: _____ Last: _____

Date of Birth (Month/Day/Year): _____ Email: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____-_____

Mailing Address (if different than home address): _____

City: _____ State: _____ Zip Code: _____-_____

Emergency Contact Name: _____ Relationship: _____

Contact Phone: _____ Email: _____

Do you need information provided in an alternate format? ☐ Large Print ☐ Spanish
☐ Interpreter: Language_____ ☐ Other _____

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Reviewed By: _____ Date: _____ Input Date: _____
ID: _____ Exp. Date: _____ Eligibility: F C T D PCA: Yes No
Conditions:

Please answer the following questions as complete and accurately as possible. Your answers will help us determine your ability to use various types of public transit.

1. Are you able to ride a Cherriots fixed route bus?

   ☐ Yes ☐ No ☐ Sometimes ☐ I do not know

   a. What limitation(s) or health-related condition(s) make it difficult or prevent you from using Cherriots fixed route buses?

   _____

   _____

   _____

   b. Are the limitations/conditions you described ☐ permanent or ☐ temporary?

   If temporary, how long do you expect this to continue? _____

   c. Does your health condition or disability change from day to day in a way that affects your ability to use fixed route buses?

   ☐ Yes ☐ No ☐ Sometimes ☐ I do not know

   If **yes** or **I do not know** is selected, explain why:

   _____

   _____

2. How do you currently travel to your most frequent destinations? Check all that apply.

   ☐ Cherriots Buses ☐ CherryLift ☐ I drive myself ☐ NEMT

   ☐ Someone drives me ☐ Taxi ☐ Other: _____

3. Do you use any of the following mobility aids or equipment? Check all that apply.

   ☐ Cane ☐ Power Wheelchair ☐ Power Scooter ☐ Crutches

   ☐ White Cane ☐ Manual wheelchair ☐ Portable Oxygen ☐ Service Animal

   ☐ Walker ☐ Other _____

4. Are you proficient in using this/these mobility aids or equipment? ☐ Yes ☐ No

5. Does a Personal Care Attendant (PCA) accompany you when you travel outside your home (Example: push your wheelchair, carry your oxygen, etc.)?

☐ Yes ☐ No ☐ Sometimes

6. Please indicate by marking yes, no, not applicable/not sure regarding **"limitations"** that may make it difficult or prevent you from using **Cherriots** fixed route services.

Travel Skills & Abilities:	Yes	No	N/A Unsure
Is your walking speed "normal", not unusually fast or slow?			
Are you able to independently walk or wheel ¼ mile? *If not, how far can you walk/wheel?* _____			
Do you have the endurance to safely and independently complete a bus trip?			
Are you stable standing and walking?			
Can you independently climb three 12" steps?			
Are you able to step up and down curbs?			
Are you able to walk or wheel up and down curb cuts?			
Can you wait independently outside for 15 minutes?			
Are you able to wait at a bus stop without a bench?			
Can you travel up or down moderately steep terrain?			
Are you able to travel on uneven or broken surfaces?			
Are you able to detect changes on surfaces?			
Are you independently able to grasp handles, railing, coins or tickets while boarding and exiting a bus?			
Can you transfer from your wheelchair or mobility device to a seat in a vehicle?			
Are you able to detect or feel changes on surfaces?			
Are you able to hear well enough to safely travel?			
Are you able to see well enough to safely travel?			
Is your short term memory adequate for safe, independent travel?			
Is your long term memory adequate for safe, independent travel?			
Are you able to travel safely and independently on the city bus?			

Travel Skills & Abilities (continued)	Yes	No	N/A Unsure
Are you able to maintain appropriate behavior in public?			
Are you able to ask for, understand and follow directions?			
Are you able to recognize destinations or landmarks?			
Are you able to recognize and respond to dangerous situations?			
Are you able to deal with unexpected situations or changes independently, without assistance?			
Are you able to seek, understand and act on directions needed to complete a trip?			
Are you able to state street address and telephone number upon request?			
Are you able to safely and effectively travel through crowded or complex facilities?			
Are you able to cross streets with various widths and with various controls safely?			
Are you able to find and remember transit system information?			
Are you able to seek, understand and act on directions needed to complete a trip?			
Are you able to walk or wheel the distance from your residence to the nearest bus stop?			
What is the nearest bus stop to your residence?			
Are you able to locate and recognize correct bus to take?			
Are you able to get on and off a bus independently when the bus is kneeled (lowered to curb and using a ramp)?			
Are you able to get to a seat or wheelchair securement area on a fixed route bus?			
Are you able to find your way in familiar and unfamiliar settings?			
Are you able to manage unexpected situations?			
Are you able to travel alone outside your home?			
Are you able to read, tell time, follow a schedule or instructions allowing for safe and independent travel?			
Are you able to adequately manage snow, ice, rain, heat, humidity, cold, bright light, low light, noise ***(circle those that you are unable to manage)***?			

5. Have you ever had training or instruction on how to use fixed route public bus service? ☐ Yes ☐ No

   a. **If yes,** what person or agency provided the training? _____

   b. Do you want or need training to use a Cherriots bus? ☐ Yes ☐ No

I certify that the information in this CherryLift/ADA Paratransit Service Evaluation is true and correct. I understand that falsification of the information may result in denial of some CherryLift eligibility services. I understand that the information in this evaluation will be kept confidential, and only the information required to provide the services for which I am eligible will be disclosed to those who perform the services. I understand that I might be asked to provide additional information necessary for a proper determination of eligibility for paratransit services.

Name of applicant (Please print): _____

Applicant's Signature: _____ Date signed: _____

Signature of person completing the form, if other than applicant:

Name (Please print):

_____

Relationship to the applicant: _____

Signature: _____ Date signed: _____

Contact Phone: _____ Email: _____

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Medical Professional Questionnaire for CherryLift/Paratransit Eligibility

Part 2 – To be filled out by your <u>Medical Professional*</u>

Date: _____

Dear _____,
Medical Professional

I, _____, have asked the Cherriots to determine my
Applicant's Name
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 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 (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.

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

Rev. 11/30/2016

First Name: _____ Last Name: _____ DOB: _____

What is CherryLift/ADA Paratransit and Who is Eligible?

CherryLift is the Americans with Disabilities Act (ADA) complementary paratransit 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 (regular city buses) due to significant functional limitations. The following features of Cherriots fixed route system allow many individuals with disabilities to use Cherriots fixed routes.

- Cherriots buses are equipped with ramps and a lower step function-kneeling (climbing steps are no longer necessary to ride fixed route 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 fixed-route 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) make it difficult or prevents the applicant from using Cherriots fixed route buses *(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 fixed route buses (regular city bus)?

PHYSICAL ABILITIES: Is the patient 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 & 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 - *does not 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 the 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 behaviors in public setting?*			
Way finding skills - *adequate for safe, independent travel?*			
Communication skills - *adequately 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*