ATTACHMENT B
Applicant with Psychiatric Disabilities

Name of Applicant: _____

Name of Licensed Physician: _____

Date Completed: _____

1. In what capacity do you know the applicant?

   _____

   _____

2. How long have you known or worked with the applicant?

   _____

   _____

3. When did you last see the applicant?

   _____

   _____

4. What is the formal diagnosis of the applicants disability (DSM-IV or other)?

   _____

   _____

5. What was the date of onset?

   _____

   _____

6. What is the prognosis?

   _____

   _____

7. Is the applicant taking any psychotropic, antidepressant or other medication(s) prescribed by you?

❑ Yes ❑ No

8. If Yes, please list the type, frequency, dose and any comments about how the medication(s) may complicate the individual's independent mobility in the community?

Medication Type	Dosage	Effect on Functional Ability (if any)

9. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community?

❑ Yes ❑ No

Comments: _____

_____

10. Do you deem the applicant to be compliant in taking prescribed medication?

❑ Yes ❑ No

Comments: _____

_____

11. Is there anything about the use of medication that would complicate the applicant's use of public transportation?

❑ Yes ❑ No

Comments: _____

_____

12. Has the applicant's functional ability decreased temporarily due to adjustment to medication?

❑ Yes ❑ No

13. If Yes, please explain and note the expected duration of the decrease in functional ability.

_____

_____

14. Does the applicant currently experience either auditory or visual hallucinations?

❑ Yes ❑ No

15. If Yes, would he/she likely to experience auditory or visual misperceptions due to hallucinations?

❑ Yes ❑ No

Comments: _____

_____

General Manager

	Yes	No	Sometimes	Comments
Travel alone outside the house				
Leave the house on time				
Seek and act on directions				
Find way to/from bus stop				
Cross Streets				
Wait for a bus				
Board the correct bus				
Ride on the bus				
Exit at the correct destination				
Transfer to a second bus				
Monitor time				
Deal with unexpected situations				

Comments: _____

_____

_____

_____

17. Are any of the following affected by his/her disability? If Yes, please explain:

	Yes	No	Sometimes	Comments
Judgement				
Problem Solving				
Insight (recognizing a problem)				
Coping skills				
Short-term memory				
Long-term memory				
Concentration				
Orientation				
Communication				
Attention to task (distractability)				

Comments: _____

_____

_____

_____

18. Would training, driver assistance or tools such as ID cards, printed route directions, etc., help to minimize the effects noted above?

❑ Yes ❑ No

Comments: _____

_____

19. Is the goal of traveling independently (even limited travel in the neighborhood) within the context of treatment?

❑ Yes ❑ No

Comments: _____

_____

20. Would the use of alternative transportation (ADA Paratransit Services) conflict with the goals of therapy, such as confidence builidng?

❑ Yes ❑ No

Comments: _____

_____

21. Would alternative transportation (ADA Paratransit Services) interfere with the applicant's therapy or involvement?

❑ Yes ❑ No

Comments: _____

_____

22. Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or over friendly? If Yes, please explain.

❑ Yes ❑ No

Comments: _____

_____

23. Comments regarding current travel and activities:

Comments: _____

_____

23. Does the individual drive a car?

❑ Yes ❑ No

Comments: _____

_____

25. Are there any other life skills that the individual lacks that would be an indication of his/her inability to travel on a Fixed Route Bus? If Yes, please describe.

❑ Yes ❑ No

Comments: _____

_____

26. Is there any additional information regarding this individual that you believe affects his/her functional ability to use regular Fixed Route Bus Service, or any special cirumstances that you believe should be considered?

Comments: _____

_____

PLACE LICENSE PHYSICIAN OFFICAL STAMP BELOW

Signature: _____ Date: _____

Print Name & Title: _____

Current Guam Medical License No. _____

Business Address: _____

_____

Mailing Address: _____

_____

Telephone No: _____ Fax No. _____