GUAM REGIONAL TRANSIT AUTHORITY

GOVERNMENT OF GUAM

Lourdes A. Leon Guerrero, Governor
Joshua F. Tenorio, Lieutenant Governor
Richard Ybanez, Interim Executive Manager

P. O. Box 2896
Hagatna, Guam 96932

Tel: (671) 475-4616/475-4686
Fax: (671) 475-9600

March 09, 2022

Dear Applicant,

Hafa Adai! Thank you for inquiring about the Guam Regional Transit Authority's (GRTA) ADA Paratransit Services. Attached is GRTA's ADA Paratransit Application Form. **Please read all the enclosed materials carefully before completing the forms.**

GRTA's ADA Paratransit Service is to provide service to individuals who, because of a **disability, are prevented** from using the standard Guam Public Transit Fixed Route Services. This might include being unable to get to or from bus stops, being unable to get on or off buses, or being unable to understand how to ride and use the system.

GRTA will provide Paratransit Services to persons determined "ADA Paratransit Eligible" for those trips that cannot be made using the Guam Public Transit System. You may, for example, be able to use the Guam Public Transit System for some trips if stops are nearby and there are no barriers which prevent you from getting to and from the bus (at other times, you might be able to get to and from and use the bus) ADA Paratransit Services is meant to assist you at these times.

There are two (2) types of ADA Paratransit Eligibility. These are:

- **Unconditional Eligibility** – this eligibility is granted if your disability prevents you from using the Guam Public Transit System for **ALL trips** that you might need to make
- **Conditional Eligibility** – this eligibility is granted if you can use the Guam Public Transit System buses under certain circumstances, but need GRTA's ADA Paratransit Services for **certain trips.**

To enable us to accurately determine your eligibility for this service, please fill out the enclosed application form **as completely and thoroughly as possible.** The questions are meant to determine specific limitations you have in using the Guam Public Transit System. They are also meant to determine **when and under what circumstances you CAN use the Guam Public Transit System buses or when GRTA's ADA Paratransit Services is required.**

After you have completed Parts 1 – 6, please have a Licensed Physician, a Health Care Professional, or a Social Worker complete Part 7 (any of Attachments A-E, only need to fill out the attachment pertaining to your disability) of the application form. The signed statement may identify and certify your disability but does not necessarily determine your eligibility for GRTA's ADA Paratransit Services. **It is important that ALL sections of the application form are complete. If any sections are left blank, the application will be returned to you or may be placed on hold.**

Information regarding your disability which you provide in your application will be kept strictly confidential.

If you need assistance in completing the application form or have any questions about our ADA Paratransit Services and Eligibility criteria's, please feel free to contact our office at:

671-475-4686 / 475-1616 (Office)
671-300-7262 (Voice)
671-475-4600 (Facsimile)

Material is also available in large print and can be provided in another format if needed. Please call our office and inform our staff of the format you require.

Completed applications will be processed in twenty-one (21) calendar days of receipt. You will be notified in writing of your eligibility for GRTA's ADA Paratransit Services. If you have not heard from us in the twenty-one (21) days, please call our office and we will provide you with paratransit services until your application is processed. Please note that in some instances, we may not be able to determine your eligibility without further information. In this case, we may ask you to schedule an In-Person Assessment to allow us to better understand your disability and transportation needs.

If you are determined to be eligible for GRTA's ADA Paratransit Services (either Unconditional or Conditional), a "Paratransit ADA Directives" which provides information about the services and how to use it will be provided to you during the In-Person Assessment or will be sent to you at the address you provided in the application. GRTA staff will take your picture for your Paratransit Rider's Identification Card here in our office.

If it is determined that you are able to use the Guam Public Transit System and therefore are not eligible for GRTA's Paratransit Services, we will notify you in writing of the exact reasons for this determination.

Sincerely,

/S/

RICHARD YBANEZ
Interim Executive Manager

Attachments

PART 1. GENERAL INFORMATION

FOR OFFICIAL USE ONLY
Type: ○ New ○ Renewal ○ Temp ○ Visitor
ID No. _____
Date Issued: _____
Date of Expiration: _____
Appt. Date: _____ Appt Time: _____
GRTA Provided Transportation: ○ Yes ○ No

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Zip Code: _____

Home Address: _____ Village: _____

Telephone No(s): (Home) _____ (Cell/Work) _____

Date of Birth: _____

If someone assisted you in completing this application, please identify them below:

Name: _____ Phone No.: _____

Do you need to have information and/or material(s) given to you in any of the following ways (check all that apply):

❑ Large Print ❑ Audio Tape ❑ Braille ❑ Other _____

Please give us the name and telephone number of someone we can call in an emergency.

Name: _____ Phone No: _____ Relation: _____

Ethnic Origin:

❑ *Non-Resident Alien* ❑ *Hispanic or Latino* ❑ *White (Not Hispanic or Latino)* ❑ *Black or African American*

❑ *Asian (Not Hispanic)* ❑ *American Indian or Alaska Native*

❑ *Native Hawaiian or Pacific Islander:* ❑ *Hawaii* ❑ *Guam* ❑ *CNMI* ❑ *Palau*

❑ *FSM Citizen:* ❑ *Chuuk* ❑ *Pohnpei* ❑ *Yap* ❑ *Kosrae* ❑ *Marshall Islands* ❑ *Other* _____

PART 2. APPLICATION CERTIFICATION

Please indicate below the reason(s) why you are seeking ADA Paratransit Eligibility (check all that apply):

- ❑ I can use the Guam Public Transit System (Fixed Route) to go some places, but in other places I cannot get to or from the bus stop
- ❑ I can use the Guam Public Transit System (Fixed Route) sometimes, but only if buses are equipped with wheelchair lifts
- ❑ Because of my disability, I am unable to use the Guam Public Transit System

I understand that the purpose of this evaluation from is to be determined if there are times when I cannot use the Guam Public Transit System provided by the Guam Regional Transit Authority (GRTA) and must therefore use GRTA's Paratransit Services. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility to use the GRTA's Paratransit Service. I certify that, to the best of my knowledge, the information in this application form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as other actions deemed necessary by the Guam Regional Transit Authority (GRTA).

Applicant's Signature: _____ **Date:** _____

PART 3. INFORMATION ABOUT THE APPLICANT'S DISABILITY

1. What type or types of disabilities prevent you from using the Guam Public Transit System (Fixed Route)(check all that apply):

- ❑ Physical Disability
- ❑ Visual Impairments/Blindness
- ❑ Developmental Disability
- ❑ Mental Illness
- ❑ Seizures
- ❑ Other _____

Please describe your disability in detail:

_____
_____
_____
_____
_____
_____

2. Is the disability described above temporary or permanent?

- ❑ Temporary, I expect it to last for another _____ months
- ❑ Permanent *(please note, Permanent disability still requires a Medical Certification every three (3) years)*
- ❑ Controlled with medication
- ❑ Not Sure

3. Please indicate below if you use any of the following mobility aides or equipment:

- ❑ Cane
- ❑ Crutches
- ❑ Alphabet Board
- ❑ Powered Scooter
- ❑ Oxygen
- ❑ Long White Cane
- ❑ Walker
- ❑ Manual Wheelchair
- ❑ Leg Braces
- ❑ Other _____
- ❑ Picture Board
- ❑ Powered Wheelchair
- ❑ Prosthesis
- ❑ Service Animal
- ❑ DO NOT USE any of the above mobility aide/equipment

NOTE: GRTA may not be able to accommodate you if your wheelchair/scooter is longer than 48" or wider than 32" or if your total weight with your wheelchair is more than 600 pounds.

4. Do you require the assistance of a Personal Care Attendant (PCA) – someone who will assist you with daily life functions when you travel?

❑ Yes ❑ Always ❑ Sometimes

Name of Personal Care Attendant: _____

If a PCA is required, assistance is needed with the following (check all that apply):

❑ Mobility ❑ Reading ❑ Eating ❑ Transfers ❑ Medications ❑ Other _____

❑ DO NOT NEED ASSISTANCE

PART 4. QUESTIONS ABOUT USING THE GUAM PUBLIC TRANSIT SYSTEM

5. Have you ever used the Guam Public Transit System?

- ❑ Yes, I typically use the Guam Public Transit System _____ a week
- ❑ I used to but stopped because _____
- ❑ No, I have never used the Guam Public Transit System

6. Is there something that might help you ride the buses (check all that apply)?

- ❑ Yes, Route and Schedule information
- ❑ Yes, learning to use the bus
- ❑ Yes, being able to get buses with lifts
- ❑ Yes, a communication aide
- ❑ Yes, if stops were closer to where I live and where I need to go
- ❑ No

7. Can you ask for and follow written and oral instructions to use the Guam Public Transit System?

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ I don't know, never tried to use the bus

If NO or Sometimes, please tell us why (check all that apply):

- ❑ I get too confused and might get lost
- ❑ Other people might not understand me
- ❑ I probably could with instructions
- ❑ Other _____

8. Are you able to GET TO and FROM bus stops on your own?

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ I don't know, never tried to use the bus

If NO or Sometimes, please tell us why (check all that apply):

- ❑ I can't get to places if there are no curb cuts
- ❑ I can't if streets/sidewalks is too steep
- ❑ I can't cross busy streets/intersections
- ❑ I can't travel outside when it's too hot
- ❑ I can't find my way at night because of my vision problem
- ❑ I get confused and can't find my way
- ❑ I probably could with instructions
- ❑ I feel unsafe traveling alone
- ❑ Other _____

9. Under the best conditions, how far can you walk outdoors (or travel using a mobility aide/equipment) without the help of another person?

- ❑ I can get to the curb in front of my house/apartment
- ❑ I can travel up to three (3) blocks (1/4 mile)
- ❑ I can travel up to six (6) blocks (1/2 mile)
- ❑ I can travel up to nine (9) blocks (3/4 mile)
- ❑ I am UNABLE to travel outside my house/apartment

10. Can you wait up to thirty (30) minutes for a Guam Public Transit System Bus?

- ❑ Yes
- ❑ Yes but ONLY IF the stop has a bench and shelter
- ❑ Yes, but I don't like to wait long
- ❑ No (please explain): _____

11. Can you GET On and GET OFF the Guam Public Transit System?

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ I don't know, never tried to use the bus

If NO or Sometimes, please tell us why (check all that apply):

- ❑ Only if the bus has a wheelchair lift
- ❑ I can't climb stairs
- ❑ I don't want to use the lift
- ❑ I probably could with instruction
- ❑ Other _____

12. If you are able to get on and get off the Guam Public Transit System Bus, can you get to a seat or wheelchair position by yourself?

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ I don't know, never tried to use the bus

If NO or Sometimes, please tell us why (check all that apply):

- ❑ I need someone to help me
- ❑ I have a balance problem
- ❑ I have trouble finding a seat
- ❑ I need the seat nearest the door
- ❑ Other _____

13. If you are able to get on and off the Guam Public Transit System buses, do you know where to get off the bus or can you find out by yourself?

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ I don't know, never tried to use the bus

If NO or Sometimes, please tell us why (check all that apply):

- ❑ I get confused and can't remember where I am going
- ❑ I can if the driver calls out the stops
- ❑ I probably could with training
- ❑ Other _____

14. Are there any other conditions which limit your ability to use the Guam Public Transit System Buses?

- ❑ Yes, please explain _____
- ❑ No

PART 5. CURRENT TRAVEL INFORMATION

15. Please give us information about where you go and how you get there now. List three (3) places you go most often.

1. Where do you go? _____

   Address: _____

   How often do you go there? _____

   How do you get there? _____

2. Where do you go? _____

   Address: _____

   How often do you go there? _____

   How do you get there? _____

3. Where do you go? _____

   Address: _____

   How often do you go there? _____

   How do you get there? _____

PART 6. INFORMATION ABOUT TRAVEL TRAINING (Survey-Data Collection Purpose Only)

Note: Travel training is personal (one-to-one) instruction that teaches an individual how to use the Guam Public Transit System Buses.

16. Have you ever had any personal instruction(s) on riding the Guam Public Transit System?

- ❑ No, I have not received any personal instruction(s)
- ❑ Yes, I received personal instruction(s) from _____

If so, indicate below all of the skills you have learned.

- ❑ to travel to and from the bus stop
- ❑ to cross streets
- ❑ to ride on the following routes (list them)
  Route: _____ Route: _____
- ❑ to read the bus schedule and plan trips
- ❑ other _____

Did you complete the above described instruction(s)? ❑ Yes ❑ No

17. Please draw a map to your place of residence. A “Residential Assessment” will be performed for bus access once your completed application has been received and reviewed.

Name: _____ Phone No: _____

Home Address: _____

This ends the portion of the application to be completed by the Applicant. The last section (on the attached pages) MUST BE COMPLETED (Signed and Stamped) by a Licensed Physician, Health Care Professional or a Social Worker.

PART 7. MEDICAL CERTIFICATION (To be completed by Licensed Physician, Health Care Professional or a Social Worker)

The American with Disabilities Act (ADA) of 1990 requires Guam Regional Transit Authority (GRTA) to provide "ADA Paratransit Services" to anyone with a disability **who cannot use the standard Guam Public Transit System Fixed Route Services** and who is traveling within a ¾ mile area serviced by a Fixed Route Service. The applicant who requests you to review and sign this application form is applying at GRTA to be considered eligible for this service. GRTA's ADA Paratransit Service is intended only for those trips on the Guam Public Transit System that the person cannot access.

This application form is intended to determine **when and under what circumstances the applicant can use GRTA's Guam Public Transit System – Paratransit Services.**

Please carefully review all the information provided by the applicant in Parts 2-4 of this application form and then complete the appropriate "Attachment" below and attached:

(a) Please complete all the appropriate assessment forms that best describes the physical and/or cognitive conditions which functionally prevents the applicant from using the standard Guam Public Transit Fixed Route Service System.

Attachment A: Applicant with Cognitive Disabilities

Attachment B: Applicant with Psychiatric Disabilities

Attachment C: Applicant with Vision Disabilities

Attachment D: Applicant with Seizure Disorders

Attachment E: Applicant with Physical Disabilities

(b) To the best of my knowledge, the information provided by the applicant in Parts 2-4 of this application is true and correct?

_____

_____

ATTACHMENT A

Applicant with Cognitive Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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. Comments about the applicant's stated ability and level of cognitive ability?

_____
_____

5. Does the applicant have any specific behavioral problems? ❑ Yes ❑ No

If yes, please explain: _____
_____

6. Does the applicant travel alone at times? ❑ Yes ❑ No

If so, where: _____
_____

7. What abilities does the applicant have in following directions to make a trip?

_____
_____

8. What abilities does the applicant have to understand time and follow a schedule to get to places on time?

_____
_____

9. What abilities does the applicant know when he/she is lost?

_____
_____

10. What abilities does the applicant have to get help if he/she is lost?

_____
_____

11. What ability does the applicant have to cross a street safely?

_____
_____

12. Comments about the applicant stated ability to travel alone.

_____
_____

13. Comments about skills related to functional abilities to travel: Orientation to person, place and time

_____
_____

14. Comments on applicant judgement and safety skills related to traveling alone?

_____
_____

15. Comments on problem solving and insight skills

_____
_____

16. Comments on short-term and long-term memory

_____
_____

17. Comments on concentration (focus attention)

_____
_____

18. Comments on ability to seek and act on direction

_____
_____

19. Comments on ability to process information

_____
_____

20. Comments on consistency (the ability to maintain a particular standard or repeat a particular task with minimal variation)

_____
_____

21. Comments on ability to communicate needs

_____
_____

22. Comments on behavioral skills

_____
_____

23. Comments about applicant's related physical skills that may affect travel (i.e. walking stability, gait, balance, physical stamina-endurance, or seizures)

_____
_____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

ATTACHMENT B

Applicant with Psychiatric Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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 applicant's 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, does 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(s) that would complicate the applicant's use of the public transportation?

❑ Yes ❑ No

Comments: _____
_____

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

❑ 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 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 there 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 (distractibility)				

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 goals of therapy, such as confidence building?

❑ 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?

_____
_____
_____

24. Does the individual drive a car? ❑ Yes ❑ No

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 circumstances that you believe should be considered?

Comments: _____
_____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

ATTACHMENT C

Applicant with Vision Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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 applicant's eye disease or condition?

Please include a visual acuity statement which indicates

a. The visual acuity for each eye
b. The field vision for each eye
c. The visual acuity with best correction for each eye

_____
_____

5. What was the date of the onset? _____

6. What is the prognosis? Is this condition stable, degenerative or otherwise changing?

_____
_____

7. Is the applicant able to walk outdoors alone? ❑ Sometimes ❑ Often ❑ Never

8. If Sometimes or Often, where can he/she travel?

Only on his/her own property	❑ Yes	❑ No
To places nearby (for example on the same block)	❑ Yes	❑ No
To places farther away	❑ Yes	❑ No

If Yes to places farther away, please explain: _____

9. If the applicant is able to travel outdoors alone, is he/she able to cross the streets without help?

At quiet streets with very little traffic	❑ Yes	❑ No
At traffic lights	❑ Yes	❑ No
At very busy intersections	❑ Yes	❑ No

Comments: _____

If the applicant is partially sighted:

10. Is he/she able to see steps or curbs?

❑ Sometimes ❑ Often ❑ Never ❑ N/A

Comments: _____

11. Is his/her vision affected by different lighting conditions?

Bright sunlight	❑ Yes	❑ No
Dimly lit or shaded places	❑ Yes	❑ No
Night time	❑ Yes	❑ No

Comments: _____

12. Is the applicant's ability to travel outside alone affected by other conditions (consider in particular the impact of environmental noise or the inability to distinguish traffic flow patterns)? If so, please describe

Comments: _____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

ATTACHMENT D

Applicant with Seizure Disorders

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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. Please describe what the applicant experiences during and after a seizure.

_____
_____

5. How often do the seizures occur?

_____
_____

6. What is the prognosis?

_____
_____

7. Are the seizures protected by an aura? ❑ Yes ❑ No

_____
_____

8. If Yes or Sometimes, does the applicant usually have time to prepare and make himself/herself as safe as possible?

_____
_____

9. Are there certain things that will trigger the applicant's seizures? ❑ Yes ❑ No

_____
_____

10. If Yes, please describe these triggers.

_____
_____

11. Please describe the applicant's ability to travel alone in the community. When and where can he/she safely travel?

_____
_____

12. What advise or limitations on traveling alone in the community have been communicated to the applicant?

_____
_____

13. Is the applicant permitted to drive? ❑ Yes ❑ No

_____
_____

14. Is the applicant taking any medication(s) prescribed by you or another professional? ❑ Yes ❑ No

_____
_____

15. 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)

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

❑ Yes ❑ No

_____
_____

17. Do you deem the applicant to be compliant in taking prescribed medication(s)? ❑ Yes ❑ No

_____

_____

18. Is there anything about the use of medication(s) that would complicate the individual's use of public transportation?

❑ Yes ❑ No

If Yes, please explain: _____

_____

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

❑ Yes ❑ No

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

_____

_____

21. Comments about the applicant's typical activities and current travel destinations.

_____

_____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

Revised 03.2022

ATTACHMENT E

Applicant with Physical Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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 applicant's disability?

_____
_____

5. What is the date of the onset?

_____
_____

6. What is the prognosis?

_____
_____

7. How does the applicant's disability/health condition affect daily life activities?

_____
_____
_____
_____

8. Please define reasonable expectations for each skill (reasonable walking distances, reasonable terrain that can be negotiated, reasonable time that applicant could stand and wait for bus, etc.)

Required Travel Skills	Reasonable Expectations
Walking distance to/from bus stops	
Stepping off/on curbs and crossing streets	
Negotiating hills/steep terrain	
Standing time at bus stop	
Boarding lift and non-lift buses	
Other	

9. Please define in more detail any environmental issues that may apply (temperature sensitivity – what temperature would present unsafe or risky conditions for the applicant)

Environmental Issues	Unsafe/Risky Conditions
Walking distance to/from bus stops	
Stepping off/on curbs and crossing streets	
Negotiating hills/steep terrain	
Standing time at bus stop	

10. Please list the type, frequency, dose and any comments about how the medication(s) may complicate the individual's independent mobility (travel) in the community.

Medication Type	Dose	Effect on Functional Ability (if any)

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____