State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

[Phone] 802-879-5900
[Fax] 802-879-5651

Agency of Human Services

PUBLIC TRANSPORTATION MEDICAL EXEMPTION APPLICATION FORM

******Instructions: Provider completes all sections and faxes form to DVHA at 879-5919******

APPLICATION SECTION:

Beneficiary's UID#: _____ Date of Birth: ____/____/____ Sex: [ ] Male [ ] Female

Last Name: _____ First Name_____ M.I.:_____

Street Address: _____ Apt. #: _____ City:_____ State: _____

Zip Code: _____ Home Phone: (____) _____

Is this a [ ] House [ ] Apartment [ ] Nursing Home?

Does this individual use a wheelchair? _____

If the individual uses a wheelchair, can he/she transfer with minimal assistance into a sedan? _____

Type of wheelchair: [ ] Manual [ ] Motorized [ ] Scooter (Three wheeled) Not Applicable [ ]

APPLICANT'S RELEASE:

I understand that the purpose of this form is to determine which mode(s) of transportation are appropriate for my medical/physical abilities in accordance with the Americans with Disabilities Act (ADA) of 1990. 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.

I certify that, to the best of my knowledge, the information in this form is true and correct. I understand that providing false or misleading information could result in a Medicaid fraud investigation. I hereby authorize my medical provider to release any and all information required by DVHA for the purpose of determining the appropriate mode(s) of transportation for my Medicaid transportation benefit.

Applicant's Signature: _____ Date: _____

If applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf.

Signing for applicant: _____ Date: _____

Print Name: _____ Relationship to applicant: _____

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MEDICAL VERIFICATION (to be completed by a Vermont licensed physician/medical provider)

The Americans with Disabilities Act of 1990 (ADA) requires all public entities operating fixed- route transportation service for the general public to also provide complementary paratransit service to persons unable to use the fixed-route system. Fixed-route busses in Vermont are designed to accommodate a wide range of physical abilities. These busses have wheelchair lifts and wheelchair attachment points. The lifts can also be used by people who cannot climb steps in order to enter the bus. These busses allow service dogs when they are specifically trained to assist an individual with a specific disability.

The applicant who has asked you to review and sign this form is applying to DVHA to be considered eligible for alternate transportation services. This application form will assist DVHA to determine when and under what circumstances the applicant can use fixed route service and when they require specialized paratransit service.

DVHA ELIGIBILITY CRITERIA:

Applicants shall be individually evaluated, and eligibility shall be determined based on a functional ability to use conventional fixed route public transportation. Functional inability to use public transportation includes the Americans with Disabilities Act (ADA) Categories 1, 2 and 3 as described in this application.

AMERICANS WITH DISABILITIES ACT (ADA) CATEGORIES:

Check the categories of eligibility that you recommend should apply.

1. [ ] The individual is unable, as a result of a physical or mental impairment (including a vision impairment), and without the assistance of another individual, (except the operator of a wheelchair lift or other boarding device), to board, ride, or disembark from an accessible bus.

2. [ ] The individual needs the assistance of a wheelchair lift or other boarding assistance device and is able, with such assistance, to board, ride, and disembark from accessible transit vehicles.

3. [ ] The individual has a specific impairment-related condition which prevents the individual from traveling to or from existing fixed route bus stops.

4. [ ] Check here if none of these categories apply.

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MEDICAL PROVIDER'S LETTERHEAD OR PRESCRIPTION FORM REQUIREMENT:

In order to process this applicant's request to become a qualified paratransit rider, we require certification from a qualified medical provider who is enrolled in Vermont Medicaid and is treating this individual for the condition(s) described in the medical certification. The certification should be written on a letterhead or prescription form with the name and address of both the medical provider and the applicant. To expedite applicant processing, please attach objective medical findings which substantiate the disability. Incomplete documentation may lead to an administrative denial of this application.

Specifically, the medical certification must address:

1. Describe in detail this individual's disability/disabilities
2. Describe the duration of the disability (is the disability permanent or temporary
3. Is the disability controlled by medication?
4. What are the physical functional requirements this person needs when traveling? For example, does the individual require an assistive device/wheelchair? Can this individual walk short distances to and from bus stops? Can this person climb steps into a bus?
5. Describe any psychological or cognitive conditions that would make it impossible for this person to use a bus.
6. Considering the fact that busses are ADA compliant and designed to accommodate a wide range of disabilities, why is this individual's condition incompatible with the use of a bus?
7. Please state how many appointments the member has missed due to this disability.
8. What is the expected outcome of this treatment and over what period of time?
9. How does the patient get to non-medical appointments/trips?

Attestation by provider:

I certify that the information I have submitted with this form is true and complete to the best of my knowledge. I further certify that I am treating this individual for the conditions described in this form.

Signature of Provider:

_____Phone #: _____

Date: _____