TOPS! Paratransit Eligibility

Form D: Cognitive or Mental Health Conditions

To be completed by a Licensed Mental Health Care Provider

Applicant's Name: _____ Date of Birth: _____

1. Please state the name of the applicant's diagnosis from the DSM? _____
2. Date of onset? _____
3. Would applicant be able to travel independently on fixed route buses if they are medication compliant? ☐ Yes ☐ No
4. Check any of the following that is affected by the individual's disability?

☐Orientation	☐Concentration	☐Monitoring time
☐Problem-solving	☐Coping Skills	☐Judgment
☐Short term memory	☐Communication	☐Gait or balance
☐Long term memory	☐Consistency	☐Social behavior
☐Aggression	☐Performance	☐Anxiety

☐Other: _____

5. Is the applicant's functional limitation permanent? ☐ Yes ☐ No
   If no, expected duration? # of Months_____ # of Years_____
6. For safety reasons, does the applicant need to travel on TOPS! at all times, with a PCA? ☐Yes ☐No If yes, please explain:

   _____

   _____
7. For safety reasons, can applicant be left unattended at pickup or drop-off locations? ☐Yes ☐No If no, please explain:

   _____

   _____

I certify the information provided above is correct.

_____ _____

Signature of Licensed Mental Health Care Provider Date

Clearly print your contact information below:

Name: _____ Board cert. # or Lic. #:_____

Phone #: _____ Fax #: _____

Business address: _____