ELIGIBILITY APPEAL QUESTIONNAIRE – MEDICAL
To be completed by a medical professional treating the applicant.

Applicant's Name: _____ Date of Birth: _____ / _____ / _____

As part of LANtaVan's in-person assessment, the applicant was deemed to be able to perform certain tasks needed to establish a reasonable expectation that the applicant could use regular fixed route transit services (i.e., not door-to-door paratransit) for transportation. Based on those observations, it was determined that the applicant was not eligible for LANtaVan door to door paratransit service. A copy of that evaluation was provided to the applicant which the applicant was instructed to provide to their medical provider for review if they would like to file an appeal of that determination. After reviewing that evaluation, please answer the questions below and sign the form. Please note that there are two (2) pages to this questionnaire. All questions must be answered in their entirety too allow us to consider an appeal. Answers must be legible to consider an appeal; please print or type except where a signature is required.

For the following questions, please use attachments for additional space if needed

1. Please review the tasks identified in the in-person assessment. Are there any tasks that the applicant was deemed able to perform that your observations of the applicant would indicate that the results of LANTA's in person assessment are inaccurate or incomplete? If yes, which tasks?

2. Please identify the diagnosed condition(s) which limits the applicant from performing the activities you listed in question 1 and how the condition(s) limits this ability.

3. Was a physical evaluation of the applicant the basis for your determination? If yes, please describe the results of this physical evaluation and how the results differ from the evaluation conducted by LANTA during the in-person assessment.

4. If you rated the applicant as not able under certain conditions to perform one or more of the activities listed above, would this inability result from certain conditions (i.e., in weather conditions, after prescribed treatments, etc.) or would the inability be unpredictable?

5. If this condition is temporary, please indicate the period during which these limitations will exist.

6. Please describe any additional factors you feel should be noted regarding the applicant's condition.

Printed Name of Treating Medical Professional:_____

Signature of Treating Medical Professional:_____

Name of Treating Medical Practice:_____

Street Address of Treating Medical Practice:_____

City, State, and Zip Code of Treating Medical Practice:_____

Telephone of Treating Medical Practice:_____

Updated: January 2020