60 W Broad St. Suite 100
Bethlehem, PA 18018

ELIGIBILITY APPEAL QUESTIONNAIRE

To be completed by a medical or mental health professional treating the applicant.

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 or mental health 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 three (3) pages to this questionnaire. All questions must be answered in their entirety to allow us to consider an appeal. Answers must be legible to consider an appeal; please print or type except where a signature is required.

Enter information regarding Applicant:

Last Name: ________________________________First Name: ___________________________M.I:.______

Address (Street and Number):____

City, State, Zip: __________________County of Residence:____

Telephone: (__________)_____________________________Date of Birth:_____________________________

The purpose of this appeal questionnaire is to describe barriers in the environment and how the applicant's disability prevents them from using the LANtaBus service. LANtaBus service refers to LANTA's system of fixed route bus routes which operate on a designated route and schedule.
Lack of LANtaBus service is not a qualifier for LANtaVan.

1. Does the applicant have a disability or disabilities that prevents them from using LANTA's fixed route bus service? ☐ Yes ☐ No

2. Is that disability(ies) (check all that apply) ____ Physical ____ Mental Health _____ Cognitive

3. What is the applicant's diagnosis(ies) that prevents the applicant's use of fixed route bus service?

 ____

 ____

4. How are you involved in the care of this diagnosis(ies)?

 ____

 ____

5. Does the applicant's disability affect their ability to complete the following travel tasks:

- Traveling alone outside the home? ☐ Yes ☐ No

  If yes, describe:____

- Leaving the house on time? ☐ Yes ☐ No

  If yes, describe:____

- Seeking and acting on directions? ☐ Yes ☐ No

  If yes, describe:____

- Walking/Finding way to/from bus stop? ☐ Yes ☐ No

  If yes, describe:____

- Crossing streets? ☐ Yes ☐ No

  If yes, describe:____

- Waiting for a bus? ☐ Yes ☐ No

  If yes, describe:____

- Boarding the correct bus? ☐ Yes ☐ No

  If yes, describe:____

- Riding on a bus? ☐ Yes ☐ No

  If yes, describe:____

- Transferring between buses? ☐ Yes ☐ No

  If yes, describe:____

- Exiting the bus at the correct destination? ☐ Yes ☐ No

  If yes, describe:____

- Monitoring time? ☐ Yes ☐ No

  If yes, describe:____

6. Was a physical evaluation of the applicant the basis for the information you provided in Q5? ☐ Yes ☐ No

7. If you rated the applicant as having limited ability to perform one or more of the activities listed in Q5, would this inability result from certain conditions (i.e., weather conditions, after prescribed treatments, etc.) or would the inability be unpredictable? ☐ Yes, results from certain conditions ☐ No, it is unpredictable

   If yes, please explain: ____

   ____

8. Are the limitations listed in Q5 temporary? ☐ Yes ☐ No

If yes, please indicate the period during which these limitations will exist (e.g. 6 months).

____

9. Is the applicant taking medication for the treatment of the diagnosis noted in Question 3 above that might be causing the limitations listed in Q5? ☐ Yes ☐ No ☐Unknown

   If yes, please describe? (Drowsiness, confusion, etc.)____

   ____

10. Would mobility training be appropriate for the applicant to address any limitations listed in Q5?
    ☐ Yes ☐ No ☐Unknown

    If No, please explain?____

    ____

11. Is the goal of traveling independently (even limited travel in the neighborhood) within the context of treatment?
    ☐ Yes ☐ No ☐Unknown

    What is the timeframe for the potential to meet this goal? _______Months

12. How will using door-to-door paratransit van service better suit the mobility needs of the applicant compared to fixed route bus service? (Please note that an increased likelihood that an applicant will attend care appointments is not a reason to grant eligibility).____

    ____

I certify that this information is true and correct to the best of my knowledge.

Printed Name of Treating Professional: ____

Signature of Treating Professional: ____

Name of Treating Practice: ____

Street Address of Treating Practice: ____

City, State, and Zip Code of Treating Practice: ____

Telephone of Treating Practice: ____

Once completed by a licensed medical or mental health care professional, this form may be submitted via one of the following methods:

- US mail to Rider Resources 60 W Broad St. Suite 100 Bethlehem, PA 18018
- Scan and email as a .PDF file to lantavanapps@lantabus-pa.gov