Hayward Operated Paratransit Program Medical Statement Form

Only required for Riders under 70 years old

Return completed form to:
Hayward Operated Paratransit Program
777 B Street, 4th Floor, Hayward, CA 94541
Tel: (510) 583-4230 | Fax: (510) 583-3650
Email: paratransit@hayward-ca.gov

This form may need to be completed if the applicant does not meet the "Senior" age (70+) eligibility requirement of the Hayward Operated Paratransit service for which they are applying. For more information, please refer to the hayward-ca.gov/residents/paratransit or call the program directly.

Applicant's Name: _____

Birthdate: _____

Address: _____

Dear Physician, Social Worker, or Health Care Professional:

The above-named person is applying for the paratransit services in the city where they reside. To determine whether this applicant is eligible for paratransit services, applicant must provide verification that they are unable to utilize public transit services independently due to a disability/disabling health condition. All information provided below is confidential and is used for the sole purpose of establishing eligibility for paratransit services. Please help us determine the eligibility status of this individual by checking and/or completing all the items below that apply to applicant. Please return this form to the applicant to submit with their paratransit application. Thank you.

1. **Please describe the applicant's disability or disabling health condition that prevents use of public transit (i.e., buses and/or BART):** Attach additional pages if needed. _____

   _____

   _____

2. **Applicant's condition is:** ☐ Permanent ☐ Temporary until (date):

3. **Due to the condition noted above, the applicant is unable to use public transit service because:**

   a. ☐ Cannot walk or travel in a wheelchair or scooter to or from a bus or train stop without the help of another person.
   b. ☐ Cannot board or get off a bus or train without the help of someone else.
   c. ☐ Cannot wait outside by him/herself for a bus or train to arrive.
   d. ☐ Cannot stand and maintain balance on a moving public transit vehicle.
   e. ☐ Cannot see, read and/or comprehend information signs, schedules, maps, etc.
   f. ☐ Cannot hear and/or comprehend verbal information given by public transit personnel
   g. ☐ Other reason(s)

4. **Are paratransit services needed for applicants to obtain life-sustaining treatment?** (i.e., dialysis, chemotherapy, radiation therapy, etc.). ☐ Yes ☐ No

Practitioner's Statement: I hereby state that the information provided above is correct.

Physician Signature: _____

Physician Name: _____ Date: _____

Discipline: ☐ Physician ☐ Nurse ☐ Social Worker ☐ Other (describe): _____

Agency/Organization Affiliation: _____

Address: _____

Telephone #: _____ Fax #: _____ Email:_____