ATTACHMENT B

Applicant with Psychiatric Disabilities

Name of Applicant:____

Name of Licensed Physician:________________________________

Date Completed:____

1. In what capacity do you know the applicant?

____

____

2. How long have you known or worked with the applicant?

____

____

3. When did you last see the applicant?____________________________

____

4. What is the formal diagnosis of the applicant disability (DSM-IV or other)?

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5. What was the date of onset?

____

____

6. What is the prognosis?____

____

7. Is the applicant taking any psychotropic, antidepressant or other medication(s) prescribed by you?

☐ YES ☐ NO

Comments:____

____

8. If YES, please list the type, frequency, dose, and any comments about how the medication(s) may complicate the individual's independent mobility in the community.

Medication Type	Dosage	Effect on Functional Ability (if any)

9. If the applicant takes his/her medication compliantly, will he/she be able to travel independently in the community?

☐ YES ☐ NO ☐ NA

Comments:____

____

10. Do you deem the applicant to be compliant in taking prescribed medication?

☐ YES ☐ NO ☐ NA

Comments:____

____

11. Is there anything about the use of medication that would complicate the applicant's use of public transportation?

☐ YES ☐ NO ☐ NA

If YES, please explain.____

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12. Has the applicant's functional ability decreased *temporarily* due to adjustment to medication?

☐ YES ☐ NO ☐ NA

13. If YES, please explain, and note the expected duration of the decrease in functional ability.____

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☐ NA

14. Does the applicant currently experience either auditory or visual hallucinations?

☐ YES ☐ NO

Comments:____

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15. If YES, would he/she be likely to experience auditory or visual misperceptions due to hallucinations?

☐ YES ☐ NO ☐ NA

Comments:____

____

16. Are any of the following skills affected by the applicant's disability? If YES, please explain, describing the effect and the extent of limitation caused by the disability. Is the applicant able to?

	Yes	No	Some-times	Comments
Travel alone outside the house				
Leave the house on time				
Seek and act on directions				
Find way to /from bus stop				
Cross streets				
Wait for a bus				
Board the correct bus				
Ride on the bus				
Exit at the correct destination				
Transfer to a second bus				
Monitor time				
Deal with unexpected situations				

Comments:____

17. Are any of the following affected by his/her disability? If YES, please explain.

	Yes	No	Some-times	Comments
Judgment				
Problem solving				
Insight (recognizing a problem)				
Coping skills				
Short-term memory				
Long-term memory				
Concentration				
Orientation				
Communication				
Attention to task (distractibility)				

Comments:____

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18. Would training, driver assistance, or tools such as ID cards, printed route directions, etc., help to minimize the effects noted above?

☐ YES ☐ NO ☐ NA

Comments:____

19. Is the goal of traveling independently (even limited travel in the neighborhood) within the context of treatment?

☐ YES ☐ NO ☐ NA

Comments:____

20. Would the use of alternative transportation (ADA paratransit service) conflict with the goals of therapy, such as confidence building?

☐ YES ☐ NO ☐ NA

Comments:____

21. Would alternative transportation interfere with the applicant's therapy or improvement?

☐ YES ☐ NO ☐ NA

Comments:____

22. Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or overly friendly)? If YES, please describe.

☐ YES ☐ NO

Comments:____

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____

23. Comments regarding current travel and activities:

Comments: ____

____

____

24. Does the individual drive a car?

☐ YES ☐ NO

Comments:____

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25. Are there any other life skills that the individual lacks that would be an indication of his/her inability to travel on a fixed route bus? If YES, please describe.

☐ YES ☐ NO

Comments:____

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26. Is there any additional information regarding this individual that you believe affects his/her functional ability to use regular fixed route bus service, or any special circumstances that you believe should be considered?

Comments:____

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PLACE LICENSE PHYSICIAN OFFICIAL STAMP BELOW:

Signature:______________________________ Date:______________

Print Name and Title:______________________________________

Current Guam Medical License No.: ___________________________

Business Address: ____

Mailing Address: ____

Telephone No.:_________________________ Fax:________________