GUAM REGIONAL TRANSIT AUTHORITY

GOVERNMENT OF GUAM

Lourdes A. Leon Guerrero, Governor
Joshua F. Tenorio, Lieutenant Governor
Pierre Tim Aguon, Interim Executive Manager

GUAM REGIONAL TRANSIT AUTHORITY
GRTA
"Nihi Ta Fan Hanao"

Dear Applicant,

Hafa Adai! Thank You for inquiring about the Guam Regional Transit Authority's (GRTA) ADA Paratransit Services. Attached is GRTA's ADA Paratransit Application Form. **Please read all the enclosed material carefully before completing the application form.**

GRTA's ADA Paratransit service is provided to individuals who, because of a **disability are prevented** from using the standard Guam Public Transit System Fixed Route Services. This might include being unable to get to or from bus stops, being unable to get on or off buses, or being unable to understand how to ride and use the system.

GRTA will provide paratransit service to person's determined "ADA Paratransit Eligible" for those trips that cannot be made using the Guam Public Transit System. You may, for example, be able to use the Guam Public Transit System for some trips if stops are nearby and there are no barriers which prevent you from getting to and from the bus [at other times, you might be able to get to and use the bus, ADA Paratransit Services is meant to assist you at these times.]

There are two (2) types of ADA Paratransit Eligibility. These are:

* **Unconditional** - An individual who is unable to use fixed route transit services under any circumstances requires unconditional eligibility, allowing the individual to make all trips using complementary paratransit.
* **Conditional** - An individual may be able to use the fixed route system for some trips. Transit agencies can establish conditional eligibility for those individuals, and would only be obligated to provide complementary paratransit for those trips that the individuals cannot make using fixed route, based on the conditions of the particular trip [Section 37.123(b)].

To enable us to accurately determine your eligibility for this service, please fill out the enclosed application form **as completely and thoroughly as possible.** The questions are meant to determine the specific limitations you have in using the Guam Public Transit System. They are also meant to determine **when and under what circumstances you can use the Guam Public Transit System buses or when GRTA's Paratransit Service is required.**

After you have completed parts **1** - 6, please have a Guam Licensed Physician, Health Care Professional or Social Worker complete Part 7 of the application with an official stamped, this will certify your disability but does not necessarily determine your eligibility for GRTA's ParatransitService, (Doctors Certification must be within one year). It is important that all sections of the application form are complete. **If any sections are left blank, the form will be returned to you.**

Information about your disability which provide in the application will be kept strictly confidential.

If you need assistance in completing the application form, or have questions about GRTA's ADA Paratransit Services and Eligibility, please feel free to contact our office at:

671-475-4686 /475-4616 (Office)
671-475-4600 (Facsimile)

Material is also available in large print and can be provided in another format if needed. Please call our office and inform our staff of the format you require.

Completed applications will be processed within twenty-one (21) calendar days of receipt. You will be notified via phone call and in writing of your eligibility for GRTA's ADA Paratransit Services. We will call you within 21 days to notify you of the eligibility decision, or to provide you with paratransit services until your application is processed. In case we have difficulty reaching you, or if you have not heard from us in 21 days, please call our office. Please note that in some instances, we may not be able to determine your eligibility without further information. In this case, we may ask you to schedule an In-Person Assessment to allow us to better understand your disability and transportation needs.

If you are determined to be eligible for GRTA's ADA Paratransit Services (either Unconditional or Conditional), a "Paratransit Rider's Guide", which provides information about the services and how to use it will be provided to you during the In Person Assessment or will be sent to you at the address you provided in the application. GRTA staff will take your picture for your Paratransit Riders Identification Card here in our office.

If it is determined that you are able to use the Guam Public Transit System and therefore are not eligible for GRTA's Paratransit Services, we will notify you in writing of the exact reasons for this determination.

Sincerely,

/S/

Pierre Tim Aguon
Interim Executive Manager

Attachments

PART 1. GENERAL INFORMATION

FOR OFFICIAL USE ONLY	
Type: ❑ New ❑ Renewal ❑ Recertification	
ID No:	
Date Issued:	
Date of Expiration:	

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Zip Code: _____

Home Address: _____ Village: _____

Telephone No: (Home): _____ (Cell/Work): _____

Date of Birth: _____

If someone assisted you in completing this form, please identify them below:

Name: _____ Phone No: _____

Do you need to have information and material given to you in any of the following ways (check all that you need):

❑ Large Print ❑ Audio Tape ❑ Braille ❑ Other

Please give us the name and telephone number of someone we can call in an emergency.

Name: _____ Phone No: _____

Relationship: _____

Ethnic Origin:

❑ Non-Resident Alien ❑ Hispanic or Latino ❑ White (Not Hispanic or Latino) ❑ Black or African American
❑ Asian (Not Hispanic) ❑ American Indian or Alaska Native
❑ Native Hawaiian or Other Pacific Islander: ❑ Hawaii ❑ Guam ❑ CNMI ❑ Palau
❑ FSM Citizen: ❑ Chuuk ❑ Pohnpei ❑ Yap ❑ Kosrae ❑ Other _____

PART 2. APPLICATION CERTIFICATION

Please indicate below the reason(s) why you are seeking ADA Paratransit Eligibility (check all that apply):

- ☐ I can use the Guam Public Transit System (Fixed Route) to go some places, but in other places I cannot get to or from the bus stop.
- ☐ I can use the Guam Public Transit System (Fixed Route) sometimes, but only if buses are equipped with wheelchair lifts
- ☐ Because of my disability, I can never use the Guam Public Transit System.

I understand that the purpose of this evaluation form is to determine if there are times when I cannot use the Guam Public Transit System provided by the Guam Regional Transit Authority (GRTA) and must therefore use GRTA's Paratransit Service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility to use the GRTA's Paratransit Service. I certify that, to the best of my knowledge, the information in this evaluation form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as other actions deem necessary by the Guam Regional Transit Authority (GRTA).

Applicant's Signature: _____ **Date:** _____

PART 3. INFORMATION ABOUT THE APPLICANT'S DISABILITY

1. What type or types of disabilities prevent you from using the Guam Public Transit System (Fixed Route) (check all that apply):

- ☐ Physical Disability
- ☐ Developmental Disability
- ☐ Other
- ☐ Visual Impairments/Blindness
- ☐ Mental Illness
- ☐ None

Please describe your disability in detail: _____

_____

_____

_____

_____

2. Is the disability described above temporary or permanent?

- ❑ Temporary, I expect it to last for another _____ months
- ❑ Permanent
- ❑ Controlled with medication
- ❑ I don't know

3. Please indicate below if you use any of the following mobility aids or equipment.

- ❑ Cane
- ❑ Crutches
- ❑ Alphabet Board
- ❑ Powered Scooter
- ❑ Other _____
- ❑ Long White Cane
- ❑ Walker
- ❑ Manual Wheelchair
- ❑ Leg Braces
- ❑ Service Animal _____
- ❑ Picture Board
- ❑ Powered Wheelchair
- ❑ Prosthesis
- ❑ DO NOT USE any of the above aids or equipment

NOTE: GRTA may not be able to accommodate you if your wheelchair/scooter is longer than 48" or wider than 32" or if your total weight with your wheelchair is more than 600 pounds.

4. Do you require assistance of a Personal Care Attendant (PCA) (someone who will assists you with daily life functions when you travel)?

- ❑ Yes
- ❑ Always
- ❑ Sometimes

Name of Personal Care Attendant: _____
(Print)

- ❑ DO NOT NEED ASSISTANCE

PART 4. QUESTIONS ABOUT USING THE GUAM PUBLIC TRANSIT SYSTEM

5. **Have you ever used the Guam Public Transit System?**

- ❑ Yes, I typically use the Guam Public Transit System _____ a week
- ❑ Yes, I used to but stopped because _____
- ❑ **No**

6. **Is there something that might help you ride the buses (check all that apply)?**

- ❑ Yes, Route and schedule information
- ❑ Yes, learning to use the buses
- ❑ Yes, being able to get buses with lifts
- ❑ Yes, a communication aide
- ❑ Yes, if stops were closer to where I live and where I need to go
- ❑ Yes, (describe) _____
- ❑ **No**

7. **Can you ask for and follow written or oral instructions to use the Guam Public Transit System?**

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ **I don't know, never tried to use the buses**

If No or Sometimes, please check all that apply:

- ❑ I get too confused and might get lost
- ❑ Other people cannot understand me
- ❑ I probably could with instruction
- ❑ Other _____

8. **Are you able to GET TO and FROM bus stops on your own?**

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ **I don't know, never tried to use the buses**

If No or Sometimes, please check all that apply:

- ❑ I can't get places if there are no curb-cuts
- ❑ I can't of streets or sidewalk is too steep
- ❑ I can't cross busy streets & intersections
- ❑ I can't travel outside when it is too hot
- ❑ I can't find my way at night because of a vision problem
- ❑ I get confused and can't find my way
- ❑ I probably could with instruction
- ❑ I feel unsafe traveling alone
- ❑ Other _____

9. **Under the best of conditions, how far can you walk outdoors (or travel using a mobility aide) without the help of another person?**

- ❑ I can get to the curb in front of my house/apartment
- ❑ I can travel up to three (3) blocks (1/4 mile)
- ❑ I can travel up to six (6) blocks (1/2 mile)
- ❑ I can travel up to nine (9) blocks (3/4 mile)
- ❑ **I am unable to travel outside my house/apartment**

10. **Can you wait up to thirty (30) minutes for a Guam Public Transit System Bus?**

- ❑ Yes
- ❑ Yes but only if the stop has a bench and shelter
- ❑ Yes but I do not like to wait long
- ❑ **No (explain):** _____

11. **Can you Get On and Off a Guam Public Transit System Bus?**

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ **I don't know, never tried to use the buses**

If No or Sometimes, please check all that apply:

- ❑ Only if the bus has a wheelchair lift
- ❑ I can't climb stairs
- ❑ I don't want to use the lift
- ❑ I probably could with instruction
- ❑ Other _____

12. **If you are able to get on and off the Guam Public Transit System Bus, can you get to a set or wheelchair position by yourself and ride the bus?**

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ **I don't know, never tried to use the buses**

If No or Sometimes, please check all that apply:

- ❑ I need someone to help me
- ❑ I have a balance problem
- ❑ I have trouble finding a seat
- ❑ I need the seat nearest the door
- ❑ Other _____

13. **If you are able to get on and off the Guam Public Transit System Buses, do you know where to get off the bus or can you find out by yourself?**

- ❑ Yes
- ❑ No
- ❑ Sometimes
- ❑ **I don't know, never tried to use the buses**

If No or Sometimes, please check all that apply:

- ❑ I get confused and can't remember where I am going
- ❑ I can if the driver calls out the stops
- ❑ I probably could with training
- ❑ Other _____

14. Are there any other conditions which limit your ability to use the Guam Public Transit System Buses?

❑ Yes, please describe: _____

_____

❑ No

PART 5. CURRENT TRAVEL INFORMATION

15. Please give us information about where you go and how you get there now. List three (3) places you go most often.

1. Where do you go? _____
   Address: _____
   How often do you go there? _____
   How do you get there? _____

2. Where do you go? _____
   Address: _____
   How often do you go there? _____
   How do you get there? _____

3. Where do you go? _____
   Address: _____
   How often do you go there? _____
   How do you get there? _____

PART 6. INFORMATION ABOUT TRAVEL TRAINING (Survey-Data Collection Purpose Only)

NOTE: Travel training is personal (one-to-one) instruction that teaches an individual how to use the Guam Public Transit System Buses.

16. Have you ever had any personal instruction on riding the Guam Public Transit System?

❑ No, I have not received any personal instruction

❑ Yes, I received personal instruction from _____

If so, indicate below all of the skills you learned.

- ❑ To travel to and from the bus stop
- ❑ To cross streets
- ❑ To ride on the following routes (list them)
  Route: _____ Route: _____
- ❑ Reading bus schedules and planning trips
- ❑ Other _____

Did you complete the above described instructions? ❑ Yes ❑ No

17. Please draw a map to your residence. A Transit Inspector will be by to address your area for bus access. (Note: Buses are NOT allowed to enter non-paved roads and single narrow access roadways.)

Name: _____ Phone No: _____

Home Address: _____

This ends the portion of the application to be completed by the Applicant. The last section (on the attached pages) MUST BE completed by a Guam Licensed Physician.

PART 7. MEDICAL CERTIFICATION (To be completed by a Licensed Physician)

The American with Disabilities Act (ADA) of 1990 requires the Guam Regional Transit Authority (GRTA) to provide "ADA Paratransit Services" to anyone with a disability **who cannot use the standard Guam Public Transit System Fixed Route Services** and who is traveling within a 3/4 mile area served by Fixed Route Services. The applicant who requests you to review and sign this form is applying at GRTA to be considered eligible for this service. GRTA's ADA Paratransit Service is intended only for those trips on the Guam Public Transit System that the person cannot access.

This application form is intended to determine **when and under what circumstances the applicant can use GRTA's Guam Public Transit System - Paratransit Services.**

Please carefully review all the information provided by the applicant in Parts 2-4 of this form and then complete the appropriate "Attachment" below:

(a) Please complete all the appropriate assessment forms that best describes the physical and/or cognitive conditions which functionally prevents the applicant from using the standard Guam Public Transit Fixed Route Services System.

Attachment A: Applicant with Cognitive Disabilities
Attachment B: Applicant with Psychiatric Disabilities
Attachment C: Applicant with Vision Disabilities
Attachment D: Applicant with Seizure Disorders
Attachment E: Applicant with Physical Disabilities

(b) To the best of you knowledge, the information provided by the applicant in Parts 2-4 of this application is true and correct?

_____

_____

ATTACHMENT A

Applicant with Cognitive Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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. Comments about the applicant's stated ability and level of cognitive ability?

_____

_____

5. Does the applicant have any specific behavioral problems? ☐ Yes ☐ No

If yes, please explain: _____

_____

6. Does the applicant travel alone at times? ☐ Yes ☐ No

If so, where: _____

_____

7. What abilities does the applicant have in following directions to make a trip?

_____

_____

8. What abilities does the applicant have to understand time and follow a schedule to get to places on time?

_____

_____

9. What abilities does the applicant know when he/she is lost?

10. What abilities does the applicant have to get help if he/she is lost?

11. What ability does the applicant have to cross a street safely?

12. Comments about the applicant stated ability to travel alone.

13. Comments about skills related to functional abilities to travel: Orientation to person, place and time

14. Comments on applicant judgement and safety skills related to traveling alone?

15. Comments on problem solving and insight skills

16. Comments on short-term and long-term memory

17. Comments on concentration (focus attention)

18. Comments on ability to seek and act on direction

19. Comments on ability to process information

20. Comments on consistency (the ability to maintain a particular standard or repeat a particular task with minimal variation)

21. Comments on ability to communicate needs

22. Comments on behavioral skills

23. Comments about applicant's related physical skills that may affect travel (i.e. walking stability, gait, balance, physical stamina-endurance, or seizures)

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

ATTACHMENT B

Applicant with Psychiatric Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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's disability (DSM-IV or other)?

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

8. If yes, please list the type, frequency, does 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

Comments: _____

_____

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

☐ Yes ☐ No

Comments: _____

_____

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

☐ Yes ☐ No

Comments: _____

_____

12. Has the applicant's functional ability decreased temporarily due to adjustment to/of medication(s)?

☐ Yes ☐ No

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

_____

_____

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Comments: _____

_____

General Manager:

	Yes	No	Sometimes	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 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 there any of the following affected by his/her disability? If Yes, please explain:

	Yes	No	Sometimes	Comments
Judgement				
Problem Solving				
Insight (recognizing a problem)				
Coping Skills				
Short-Term Memory				
Long-Term Memory				
Concentration				
Orientation				
Communication				
Attention to task (distractibility)				

Comments: _____

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

❑ Yes ❑ No

Comments: _____

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

☐ Yes ☐ No

Comments: _____

_____

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

☐ Yes ☐ No

Comments: _____

_____

21. Would alternative transportation (ADA Paratransit Services) interfere with the applicant's therapy or involvement?

☐ Yes ☐ No

Comments: _____

_____

22. Does the applicant demonstrate inappropriate social behavior (for example, is he/she aggressive or over friendly) if Yes, please explain?

☐ Yes ☐ No

Comments: _____

_____

23. Comments regarding current travel and activities?

_____

_____

_____

24. Does the individual drive a car? ☐ Yes ☐ No

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: _____

_____

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: _____

_____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

ATTACHMENT C

Applicant with Vision Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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's eye disease or condition?

Please include a visual acuity statement which indicates

a. The visual acuity for each eye
b. The field vision for each eye
c. The visual acuity with best correction for each eye

_____

_____

5. What was the date of the onset? _____

6. What is the prognosis? Is this condition stable, degenerative or otherwise changing?

_____

_____

7. Is the applicant able to walk outdoors alone? ☐ Sometimes ☐ Often ☐ Never

8. If Sometimes or Often, where can he/she travel?

Only on his/her own property	☐ Yes	☐ No
To places nearby (for example on the same block)	☐ Yes	☐ No
To places farther away	☐ Yes	☐ No

If Yes to places farther away, please explain: _____

9. If the applicant is able to travel outdoors alone, is he/she able to cross the streets without help?

At quiet streets with very little traffic	☐ Yes	☐ No
At traffic lights	☐ Yes	☐ No
At very busy intersections	☐ Yes	☐ No

Comments: _____

If the applicant is partially sighted:

10. Is he/she able to see steps or curbs?

☐ Sometimes ☐ Often ☐ Never ☐ N/A

Comments: _____

11. Is his/her vision affected by different lighting conditions?

Bright sunlight	☐ Yes	☐ No
Dimly lit or shaded places	☐ Yes	☐ No
Night time	☐ Yes	☐ No

Comments: _____

12. Is the applicant's ability to travel outside alone affected by other conditions (consider in particular the impact of environmental noise or the inability to distinguish traffic flow patterns)? If so, please describe

Comments: _____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

ATTACHMENT D

Applicant with Seizure Disorders

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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. Please describe what the applicant experiences during and after a seizure.

5. How often do the seizures occur?

6. What is the prognosis?

7. Are the seizures protected by an aura? ☐ Yes ☐ No

8. If Yes or Sometimes, does the applicant usually have time to prepare and make himself/herself as safe as possible?

9. Are there certain things that will trigger the applicant's seizures? ☐ Yes ☐ No

10. If Yes, please describe these triggers.

11. Please describe the applicant's ability to travel alone in the community. When and where can he/she safely travel?

12. What advise or limitations on traveling alone in the community have been communicated to the applicant?

13. Is the applicant permitted to drive? ☐ Yes ☐ No

14. Is the applicant taking any medication(s) prescribed by you or another professional? ☐ Yes ☐ No

15. 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)

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

☐ Yes ☐ No

17. Do you deem the applicant to be compliant in taking prescribed medication(s)? ☐ Yes ☐ No

_____

_____

18. Is there anything about the use of medication(s) that would complicate the individual's use of public transportation?

☐ Yes ☐ No

If Yes, please explain: _____

_____

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

☐ Yes ☐ No

20. If Yes, please explain and note the expected duration of the decrease in functional ability.

_____

_____

21. Comments about the applicant's typical activities and current travel destinations.

_____

_____

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____

Revised 03.2022

ATTACHMENT E

Applicant with Physical Disabilities

Name of Applicant: _____

Name of Licensed Physician, Health Care Professional or Social Worker: _____

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's disability?

5. What is the date of the onset?

6. What is the prognosis?

7. How does the applicant's disability/health condition affect daily life activities?

8. Please define reasonable expectations for each skill (reasonable walking distances, reasonable terrain that can be negotiated, reasonable time that applicant could stand and wait for bus, etc.)

Required Travel Skills	Reasonable Expectations
Walking distance to/from bus stops	
Stepping off/on curbs and crossing streets	
Negotiating hills/steep terrain	
Standing time at bus stop	
Boarding lift and non-lift buses	
Other	

9. Please define in more detail any environmental issues that may apply (temperature sensitivity – what temperature would present unsafe or risky conditions for the applicant)

Environmental Issues	Unsafe/Risky Conditions
Walking distance to/from bus stops	
Stepping off/on curbs and crossing streets	
Negotiating hills/steep terrain	
Standing time at bus stop	

10. Please list the type, frequency, dose and any comments about how the medication(s) may complicate the individual's independent mobility (travel) in the community.

Medication Type	Dose	Effect on Functional Ability (if any)

PLACE License Physician, Health Care Professional or Social Worker Official STAMP BELOW

Signature: _____ Date: _____

Print Name and Title: _____

Current Guam Medical License No./Official No: _____

Business Address: _____

Mailing Address: _____

Telephone No(s): _____ Fax No: _____