VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Department of Vermont Health Access
208 State Drive, NOB 1 South
Waterbury, VT 05671-1010
Phone: (802) 879-5900
Fax: (802) 879-5919

Public Transportation Medical Exemption Application

Please fax this form to 802-879-5919.

Member's Medicaid ID #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Last Name: _____ First Name_____ M.I.:_____

Street Address: _____ Apt. #: _____ City:_____ State: _____

Zip Code: _____ Home Phone: _____ Email Address: _____

Does this individual use a wheelchair? Yes ☐ No ☐
If yes, can the individual transfer with minimal assistance into a sedan? _____

Type of wheelchair: ☐ Manual ☐ Motorized ☐ Scooter (Three wheeled) ☐ Not Applicable

Other assistive device: ☐ Walker ☐ Other_____

Medical Verification (to be completed by a Vermont licensed physician/medical provider)

The Americans with Disabilities Act of 1990 (ADA) requires all public entities operating fixed- route transportation service for the general public to also provide complementary paratransit service to persons unable to use the fixed-route system. Fixed-route busses in Vermont are designed to accommodate a wide range of physical abilities. These busses have wheelchair lifts and wheelchair attachment points. The lifts can also be used by people who cannot climb steps in order to enter the bus. These busses allow service dogs when they are specifically trained to assist an individual with a specific disability.

The applicant who has asked you to complete this form is applying to DVHA to be considered eligible for alternate transportation services. This application form will assist DVHA to determine when and under what circumstances the applicant can use fixed route service and when they require specialized paratransit service.

DVHA USE ONLY - Authorized By: _____Date:_____

Approved ☐ Exp. Date: _____ Denied ☐

Revised 12/8/21

DVHA Eligibility Criteria:

Members who live within three quarters of a mile of a bus route are required to utilize that mode of transportation. If there are medical restrictions, applicants shall be individually evaluated, and eligibility shall be determined based on a functional ability to use conventional fixed route public transportation. Functional inability to use public transportation includes the Americans with Disabilities Act (ADA).

To process this applicant's request to become a qualified paratransit rider, we require certification from a qualified medical provider who is enrolled in Vermont Medicaid and is treating this individual for the condition(s) described in the medical certification. The certification should be written on letterhead with the name and address of both the medical provider and the applicant. To expedite applicant processing, please attach the certification addressing the following questions in detail along with recent clinical notes pertaining to the member's condition(s). Incomplete documentation may lead to an administrative denial of this application.

Medical certification on letterhead must address all questions below in detail:

1. Describe this individual's physical, psychological, or cognitive disability/disabilities.
2. Describe the duration of the disability. Is the disability permanent or temporary? If temporary, please provide the anticipated timeframe.
3. Is the disability controlled by medication?
4. What is the expected outcome of this treatment and over what period of time?
5. Can this individual go the distance to and from bus stops either with or without the use of an assistive device/wheelchair?
6. Considering that busses are ADA compliant and designed to accommodate a wide range of disabilities, why is this individual's condition incompatible with the use of a bus?
7. Please state how many appointments the member has missed/canceled/attended in the past year.
8. How does the patient get to non-medical appointments/trips?

If the above questions are not addressed in enough detail, DVHA may request the submission of additional information.

Attestation by provider:

I certify that the information I have submitted with this form is true and complete to the best of my knowledge. I further certify that I am treating this individual for the conditions described in this form.

Signature of Provider: _____ Date: _____

Phone Number: _____ Fax Number: _____