MENTAL HEALTH DISABILITY PROFESSIONAL VERIFICATION

This form provides supplemental information about an individual's disability. This form should be included with the individual's application for LANtaVan services or submitted as part of an appeal. This professional verification is to be completed by a community supports program professional, intensive case manager, psychologist, psychiatrist or other mental health professional familiar with the below named's mental health disability. Please complete this professional verification form as thoroughly as possible. **This form should be completed in its entirety and must be legible or a new verification will be required.** This information will be kept confidential and used only by the professionals involved in evaluating the below named's eligibility for LANtaVan service. If you have any questions, please call LANtaVan at (610) 432-3200.

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

Address (Street and Number):_____

City:_____ State:_____ Zip Code:_____

County of Residence:_____ Gender:_____

Telephone: Home (____)_____ Cell (____)_____ Work ( )_____

E-Mail:_____

Social Security Number:_____ Date of Birth:_____ Age:_____

1. a. In what capacity do you know this individual? _____

   _____

   b. How long have you known this individual? _____

2. What was the last date of face to face contact (by you or your agency) with this individual?_____

   _____

3. What is the individual's diagnosis? (DSM-V) _____

4. Date of onset (if known)? _____

5. Is the prognosis acute or chronic? _____

6. Is individual taking medication for the treatment of the diagnosis noted in Question 3 above?
☐ Yes ☐ No ☐Unknown

   a. Does the above medication(s) affect individual's functional ability to travel independently on a fixed route bus (LANtaBus)? (Drowsiness, confusion, etc.)_____

7. Has the individual's functional ability changed temporarily due to adjustment to medication?
☐ Yes ☐ No ☐Unknown

   If yes, please explain and give expected duration. _____

8. When taking medication compliantly, will the individual be able to travel independently on a bus in the community? ☐ Yes ☐ No ☐Unknown

9. Does the individual drive? ☐ Yes ☐ No ☐Unknown

10. Does the individual currently experience either auditory or visual hallucinations?
☐ Yes ☐ No ☐Unknown

    If yes, would s/he be likely to experience auditory or visual misperceptions due to hallucinations?
☐ Yes ☐ No ☐Unknown

11. Is individual's disability the same every day? ☐ Yes ☐ No ☐Unknown

    If no, please answer a, b and c.

    a. Does this individual have days when they are well enough to use LANtaBus service?

       ☐ Yes ☐ No ☐Unknown How many days last month? _____Days _____Unknown

    b. Does this individual have days when they are not well enough to use LANtaBus service but can travel?

       ☐ Yes ☐ No ☐Unknown How many days last month? _____Days _____Unknown

       Does anything trigger this type of day? ☐ Yes ☐ No ☐Unknown

       Explain:_____

    c. Does this individual have days when they cannot travel at all?

       ☐ Yes ☐ No ☐Unknown How many days last month? _____Days _____Unknown

12. Are any of the following affected by individual's disability? Check ALL that apply:

_____Disorientation
_____Problem-solving
_____Short-term memory
_____Long-term memory
_____Concentration
_____Gait or balance
_____Monitoring time
_____Judgement
_____Communication
_____Inconsistent performance
_____Coping skills
_____Inappropriate social behavior – describe
_____Aggressive/violent
_____Sexual
_____Over-friendly

_____Other - describe:_____

_____

Please explain how the above interferes with safe community travel: _____

_____

13. Describe how the individual's disability affects his/her ability to complete the following travel tasks:

- Traveling alone outside._____
- Leaving the house on time._____
- Seeking and acting on directions._____
- Finding way to/from bus stop._____
- Crossing streets._____
- Waiting for a bus._____
- Boarding the correct bus._____
- Riding on a bus._____
- Transferring to a second bus or exiting at the correct destination._____

  _____
- Monitoring time._____

14. Would mobility training be appropriate for this individual? ☐ Yes ☐ No ☐ Unknown

If No, please explain?_____

_____

15. Would training tools help? (Ex: memory cards, written route directions, photos, etc.).
☐ Yes ☐ No ☐ Unknown

If no, please explain:_____

_____

16. 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

17. How will using LANtaVan better suit this individual than LANtaBus service?_____

_____

18. Is there any additional information regarding this individual which you believe impacts his/her functional ability to use LANTA fixed route service (LANtaBus) or any special circumstance which you believe should be considered?_____

_____

_____

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

_____ _____
Signature Title

_____ _____
Printed name Printed title

_____ _____
Agency Date

_____
Address

_____
Phone