



**-Authorization to Release Medical Information-**

**-To be completed by the applicant-**

I authorize the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition, to release this information to Skagit Transit. This information will only be used to verify my eligibility for Paratransit services. I understand that I have the right to receive a copy of this authorization and that I may revoke it at any time.

Name of professional who may release my medical information:

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Address: -----

City: ----- State: ----- Zip: -----

Daytime Phone #: (-----) -----

Medical Record or ID #, if known: -----

SIGN HERE:

Applicant's Signature: -----

Date: -----



This concludes the applicant's portion of the form. Please have your treating physician review your application and complete the Medical Professional Verification Form. The entire packet (Application and Medical Verification Form) must be completed and submitted to Skagit Transit to initiate the eligibility determination process. Please call 360-757-9191 if you have questions about this process.



# SKAGIT TRANSIT

## -Medical Professional Verification Form-

**-(To be completed by a licensed medical or mental health professional)-**

Applicant's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### Licensed Medical or Mental Health Professional Verification

Please check one:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Medical doctor (MD)                         | <input type="checkbox"/> Optometrist       | <input type="checkbox"/> Psychologist (Ph.D.) |
| <input type="checkbox"/> Orthopedic Doctor                           | <input type="checkbox"/> Neurologist       | <input type="checkbox"/> Psychiatrist         |
| <input type="checkbox"/> Nurse Practitioner                          | <input type="checkbox"/> Spinal Specialist | <input type="checkbox"/> LCSW                 |
| <input type="checkbox"/> Physical / Occupational Therapist           | <input type="checkbox"/> Ophthalmologist   |   |
| <input type="checkbox"/> Certified Orientation & Mobility Specialist |  |   |

Instructions: This applicant is applying for Skagit Transit ADA Paratransit transportation services. In accordance with the Americans with Disabilities Act of 1990, ADA Paratransit service is available only for persons who, because of a disability, are prevented from taking the regular Fixed Route bus. All Skagit Transit public transit buses are equipped with ramps/lifts for people who cannot climb stairs. The applicant could be prevented in either of the following ways: 1) is unable to independently get to and from a bus stop, on or off the bus, or successfully navigate to a destination or 2) is unable to understand how to complete a bus trip.

For the benefit of the applicant, please answer the following questions as fully and accurately as possible. Please be specific when answering the questions or write N/A (not applicable). Incomplete answers will result in the application being returned to the applicant. All healthcare information will be kept confidential. Call Skagit Transit's Eligibility Department at 360-757-9191 if you have any questions.

Please fax completed form to Skagit Transit Eligibility Department at **360-757-4032**.

Thank you.

## -Medical Professional Verification Form continued-

1. Based on your knowledge of the applicant's condition, is the information provided on their ADA paratransit application accurate?

\_\_\_\_ YES                      \_\_\_\_ SOMEWHAT                      \_\_\_\_ NO

If you checked "SOMEWHAT" or "NO" please explain:

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2. What specific conditions contribute to the applicant's mobility and/or cognitive limitations? Please define the degree of impairment and include visual acuity, if applicable.

NOTE: Age or the inability to drive are not qualifying factors.

DIAGNOSIS \_\_\_\_\_

DISABILITY \_\_\_\_\_

DATE OF ONSET \_\_\_\_\_

DEGREE OF IMPAIRMENT \_\_\_\_\_

Please explain how the applicant's disability prevents them from using the regular bus system:

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3. The disability that prevents the applicant from accessing the regular bus system is:

\_\_\_\_ Permanent                      \_\_\_\_ Temporary - Expected recovery date: \_\_\_\_\_

Are any of the following skills effected by the applicant's disability such that they **prevent** the use of our Fixed Route bus service? (Please check all that apply)

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| ____ Travel alone outside the house  | ____ Leave the house on time         |
| ____ Seek and act on directions      | ____ Find way to/from a bus stop     |
| ____ Cross streets                   | ____ Board, ride and disembark a bus |
| ____ Exit at the correct destination | ____ Transfer to a second bus        |
| ____ Deal with unexpected situations | ____ Monitor time                    |

Are any of the following effected by the applicant's disability such that they prevent the use of our Fixed Route bus service? (Please check all that apply)

- |                        |   |
|------------------------|---|
| ____ Judgement         | ____ Short-term memory                  |
| ____ Coping skills     | ____ Orientation, recognizing a problem |
| ____ Concentration     | ____ Long-term memory                   |
| ____ Attention to task | ____ Communication                      |
| ____ Problem solving   |   |



# SKAGIT TRANSIT

## -Medical Certification for Paratransit Service-

### -SUMMARY OF ASSESSMENT-

To be eligible for Paratransit, an individual must have a disability that prevents use of our Fixed Route bus service. If an applicant is uncomfortable or inconvenienced using our Fixed Route bus service, that is not a justification for eligibility, and will not be taken into consideration.

- In your professional opinion, is this person capable of traveling independently throughout the community in a Fixed Route city bus, with little to no assistance? \_\_\_\_ YES \_\_\_\_ NO
- Please explain why this person is or is not capable of traveling independently in a Fixed Route city bus:

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- Attached additional relevant medical information \_\_\_\_ YES \_\_\_\_ NO
- What is the nature of your medical practice? (e.g., family/general practice, internal medicine, psychiatry, cardiology, etc.)

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I am a licensed medical professional as described above; I certify that the information on this form and any additional information submitted therein are true and correct. Upon consent of the applicant, I agree to release this applicant's relevant medical records upon request from Skagit Transit.

Physician's Signature \_\_\_\_\_ Date\_\_\_\_\_

Licensed Physician's Information (type, print, or stamp):		
Last Name	First Name	Middle Name
Licensed Number	Phone Number	Fax Number
Business Address		