



APPLICATION FORM
**Metropolitan Area Transit
Special Transportation Services
for Persons with Disabilities**



This application form is used by Metro Area Transit to determine an individual with disabilities eligibility for MAT Paratransit and/or half-fare on MAT Fixed Route Bus System in the cities of Fargo/West Fargo, North Dakota and Moorhead/Dilworth, Minnesota. If you have any questions, contact the Transit Office listed below.

Senior citizens who are not disabled should complete a different application form for senior discounts and services.

SEND COMPLETED APPLICATION FORM TO:

Metro Area Transit
650 23 St. N.
Fargo, ND 58102

Transit Office: 701-476-6782
Fax: 701-241-8558
TDD/Relay: 7-1-1

Please answer all of the questions. An incomplete application will be returned. The applicant will receive by mail a written determination of acceptance or denial of eligibility within 21 days following receipt of a completed application and professional verification.

1. Last Name _____
First Name _____ Middle Initial _____
Maiden Name (If applicable) _____
2. Address _____

City _____ State _____ Zip _____
3. Daytime phone: _____ Evening phone: _____
4. Applicant's Date of birth: ____ / ____ / ____
5. Do you have a Medicare card? Yes _____ No _____
6. List the name of one person or agency that we may contact in the case of an emergency:
Name: _____
Address: _____
Daytime phone: _____ Evening phone: _____

7. Do you have a physical or mental impairment?

Physical _____ Mental _____ Both _____

8. What is your disability? _____

9. Is this condition temporary? Yes _____ No _____

If Yes, what is the expected duration: _____ / _____ / _____

10. Does this disability **prevent** you from using Metropolitan Area Transit (MAT) Fixed Route Bus Service (the city bus) independently? For instance: to utilize Fixed Route Services (city bus), you may need to travel up to 1/4 mile to the bus stop, wait outside for up to 10 minutes, climb 1-3 steps into bus, and be able to navigate the system (recognize destinations, understand transfers, distinguish between vehicles).

Yes _____ No _____ Sometimes _____

If you answered "NO" to Question 10, skip to Question 26.

11. **How** does this disability prevent you from using MAT Fixed Route Services? Please explain completely. **If you answered "sometimes" to question 10, explain the circumstances.** Use an additional sheet if needed.

12. Are there any other effects of your disability of which we need to be aware?

13. Do you need a Personal Care Attendant to assist you when you travel?

Yes _____ No _____ Sometimes (explain) _____

14. Will you **regularly** need driver assistance to/from the bus or van?

Yes _____ No _____

15. Do you use any of the following aids to mobility? (Check all that apply.)

_____ Electric Wheelchair

_____ Manual Wheelchair

_____ Scooter

_____ Geri Chair

_____ Cane

_____ Walker

_____ Guide Animal

_____ Crutches

_____ Life Support Equipment: _____

_____ Other: _____

16. If you use a wheelchair, can you operate the controls yourself?

Yes _____ No _____ Sometimes _____

17. Does temperature or weather affect your disability?

Yes _____ No _____

If yes, what temperatures or weather and how do they limit you?

18. Does your disability affect your ability to physically travel in the community?

Yes _____ No _____ Sometimes _____

If you answered "NO" to Question 18, skip to Question 22.

19. Can you travel the following distance outside **without** the assistance of another person? Travel includes using mobility aids such as a wheelchair, walker, cane, etc.

200 feet (about 1/2 block)

Yes _____ No _____ Sometimes (explain) _____

440 feet (about 1 block)

Yes _____ No _____ Sometimes (explain) _____

880 feet (about 2 blocks)

Yes _____ No _____ Sometimes (explain) _____

1/4 mile (about 3 blocks)

Yes _____ No _____ Sometimes (explain) _____

3/4 mile (about 9 blocks)

Yes _____ No _____ Sometimes (explain) _____

20. Can you climb steps without assistance?

one 12-inch step: Yes _____ No _____ Sometimes (explain) _____

three 12-inch steps: Yes _____ No _____ Sometimes (explain) _____

21. Can you wait outside without support for ten minutes?
 Yes ___ No ___ Sometimes (explain) _____
22. Do you have a mental or psychological disability? Yes _____ No _____
23. Are you sight impaired or legally blind? Yes _____ No _____

If you answered "NO" to questions 22 and 23, skip to question 26.

24. Are you able to:
 give addresses and telephone numbers upon request?
 Yes ___ No ___ Sometimes (explain) _____
- recognize a destination or landmark?
 Yes ___ No ___ Sometimes (explain) _____
- deal with unexpected situations or unexpected change in route?
 Yes ___ No ___ Sometimes (explain) _____
- ask for, understand and follow directions?
 Yes ___ No ___ Sometimes (explain) _____
- safely and effectively travel through crowded and/or complex facilities?
 Yes ___ No ___ Sometimes (explain) _____
25. Do you a need large print or audio version of the transit brochure?
 No _____ Yes, large print _____ audio cassette _____ CD (compact disc) _____

26. I hereby certify that the information given above is correct.
 Signed _____ Date ____ / ____ / ____

27. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name _____
 Address _____

 City _____ State _____ Zip _____
 Telephone Number (Home) _____ (Work) _____
 Signed _____ Date ____ / ____ / ____

If we have questions on your application, we will contact you. Would you rather we contact the person who filled out the application on your behalf listed above?

Yes ___ No ___ By answering yes, you are authorizing MAT and the person listed above to discuss your medical information.

AUTHORIZATION FORM

Name of Applicant: _____

In order to allow Metro Area Transit to evaluate your request for certification for special transportation services for persons with disabilities, it may be necessary for us to contact a physician or other professional with access to your medical records to confirm the information you have provided. If you do not allow Metro Area Transit to contact your physician or other professional, we will not be able to process your request. Please complete the following information and authorization form and return with your application.

The person listed below is familiar with my disability and is authorized to complete the professional verification form that Metro Area Transit requires to determine my qualifications for special transportation services. Once this information is provided to Metro Area Transit, it may be subject to redisclosure and no longer protected by the privacy rule.

FILL IN THE FOLLOWING INFORMATION ON A PHYSICIAN OR PROFESSIONAL WHO IS FAMILIAR WITH YOUR DISABILITY -- PLEASE PRINT

The individual listed below is a:

- _____ Physician
- _____ Health Care Professional
- _____ Rehabilitation Professional
- _____ Social Service Agency Professional with access to medical records

Physician's or Professional's Name _____

Clinic or Business Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number (Work) _____

I understand that I have a right to revoke this authorization. This authorization will expire (date/event) _____ OR automatically in 12 months from date of signature.

Signature of Applicant:

_____ Date ____ / ____ / ____

NOTE: Any medical fees associated with providing this information is the responsibility of the applicant or client and not the Cities of Fargo or Moorhead or Metro Area Transit.

For use if you have a **Sanford** provider.

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient _____ Chart No. _____

Date of Birth: _____ Phone # _____

I authorize:

To release to:

Sanford Health System
PO BOX MC
Fargo, ND 58122-0007
PHYSICIAN NAME: _____

Metro Area Transit
650 23rd Street North
Fargo, ND 58102

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED
(specify dates for each, unless "entire medical record" is selected)

- _____ MeritCare treatment from _____ (date) to _____ (date)
- _____ Hospital Admission Summary _____ Lab Reports _____ Pathology Report
- _____ Hospital Discharge Summary _____ X-ray Reports _____ Billing Information
- _____ Entire Medical Record for all dates _____ X-ray Films/CD _____ Immunizations
- _____ Progress Notes/Clinic Notes _____ Psychiatric Intake _____ Operative Report

Other (please specify) _____
_____ MAT Transit Transportation Form _____

Verbal discussion only - do not release any written records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:
Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

- _____ Further Treatment (Date of Appointment _____) _____ Insurance Application
- _____ Personal Records _____ Education _____ Disability Determination
- _____ Vocational Rehabilitation Evaluation At my request _____ Payment of Insurance Claims
- _____ Legal _____ Other _____

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 months from the date of signing.

A photocopy or fax of this authorization will be treated in the same manner as the original.

Signature of Patient/Guardian/Representative

Date

(If not patient, state authority/relationship)

