TRANSITPLUS
PARATRANSIT SERVICE

1942 North 17th Street
Milwaukee, Wisconsin 53205-1697

Phone: (414) 343-1700
TTD: (414) 343-1704

Medical Verification for Transit Plus Service

Patient Consent

By checking this box I certify that I have received authorization from the patient listed below to provide verification of known medical conditions/disabilities for the purpose of evaluating eligibility for the Transit Plus Program. *

☐ Authorized

Patient Information

Patient's Last Name *

Patient's First Name *

Patient's Middle Name

Patient's DOB *

Date

Federal law requires that Transit Plus provide comparable paratransit services to persons who cannot use available Fixed Route bus service. The information provided will allow Transit Plus to make an appropriate evaluation of this applicant's functional abilities. Please fill in all sections that pertain to the applicant's disabilities as they relate to using public transportation.

Your patient's application for Transit Plus eligibility will be reviewed to determine whether they qualify for Paratransit services under the Americans with Disabilities Act (ADA).

A person's eligibility for Paratransit services is dependent upon:

1.) Inability to navigate the system independently;

2.) Lack of accessible vehicles, stations, or bus stops
(All MCTS buses are accessible with a ramp for boarding and kneeling feature); or

3.) Inability to reach a boarding point or final destination.

Evaluation of Functional Limitations

What is the nature of the disability/condition? (Check all that apply)

☐ Intellectual ☐ Sensory ☐ Physical

Please note that if applicant has a visual impairment; the visual acuity questions are required for application to be considered complete.

Visual Acuity (with best correction):

Left Eye

Right Eye

Visual Fields:

Left Eye

Right Eye

Light Perception:

Left Eye

Right Eye

What is/are the applicant's disabilities/ diagnosis?

If multiple conditions/ disabilities are listed; identify the most limiting condition affecting the patient's ability to utilize public transportation on the fixed route bus.

When did you last see the applicant for said condition(s)?

Date

Is this most limiting condition:

- [ ] Temporary
- [ ] Permanent
- [ ] Progressive

What is the current severity of the above condition?

- [ ] Mild
- [ ] Moderate
- [ ] Severe

In your professional opinion is this applicant prevented from utilizing public transit due to their disability/condition? *

- [ ] Yes
- [ ] Sometimes
- [ ] No

How is the applicant being treated for the listed disability/ condition?

Medication

Mobility Device

Therapy

Programs

Surgical Procedure

Other

How is the applicant managing/responding to treatment?

- [ ] Worsening Condition
- [ ] Stable
- [ ] Somewhat Effective
- [ ] Very Effective

Is the applicant prevented by disability from independently completing daily activities? *

☐ Yes ☐ Sometimes ☐ No

Certification of Diagnosis

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true and represents the current physical and/or mental condition of the applicant named on this form.

Professional's Name *

Professional's Title/Position

Professional's License/NPI Number *

Office or Facility Address

Office Phone *

Please enter a valid phone number.

Email *

example@example.com

Professional's Signature *

Date *

Date

(Please Note: This application is only valid for up to 90 days from date of signature)

Should you have any questions please call the Transit Plus Office at: (414) 343-1700