



**APPLICATION FORM**  
**REQUEST FOR CERTIFICATION**  
**AS VERIFYING AGENCY/ORGANIZATION**  
**MATBUS**

This application form is used by the Cities of Fargo, North Dakota, and Moorhead, Minnesota, to determine an agency or organization's eligibility to provide medical verification as to an individual with a disability's eligibility for special services or rates on the MATBUS System. If you have any questions, contact the appropriate Transit Office at the address or telephone number listed below.

**Send completed application form to:**

MATBUS  
650 23<sup>rd</sup> Street North  
Fargo, ND 58102

Transit Office: 701-241-8140

TDD/Relay: 7-1-1

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1. Name of Agency/Organization

\_\_\_\_\_

2. Address of Agency/Organization

\_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Brief description of type of clients you serve.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Do you have medical personnel on staff?

Yes \_\_\_\_\_ No \_\_\_\_\_

4a. If **yes**, check which one of the following apply:

- \_\_\_\_\_ Physician
- \_\_\_\_\_ Rehabilitation Professional
- \_\_\_\_\_ Health Care Professional

4b. If **no**, you must have medical records available to you that have been provided by a licensed physician, rehabilitation professional or health care professional. Give the name(s) and title(s) of up to two individuals from your agency/organization whom are authorized to provide verification of an individual's disability to Moorhead Transit.

Name and Title \_\_\_\_\_

Name and Title \_\_\_\_\_

5. I hereby certify that the information given above is correct.

Signed \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name and Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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**OFFICE USE ONLY**

DATE INITIALS

\_\_\_\_\_ Date Completed Application Received

\_\_\_\_\_ Date Determination Made

\_\_\_\_\_ Date Notification of Eligibility Mailed

If denied, reason: \_\_\_\_\_