



MAT Paratransit Application

for Persons with Disabilities

This application form is used by MATBUS to determine eligibility for MAT Paratransit for persons with disabilities with limited ability to use the MATBUS fixed route service in the cities of Fargo/West Fargo, North Dakota and Moorhead/Dilworth, Minnesota. **Those applying for discount fare on the MATBUS fixed route only due to disability and not Paratransit must complete a different application form.** Anyone who is Paratransit eligible is automatically eligible for discount fare on the MATBUS fixed route.

MATBUS sends a form to verify your disability to the professional you identify on the authorization form. A final determination of eligibility will occur within 21 days of receiving the application form, authorization form, and professional verification form. If Paratransit eligibility is denied, the reason for the finding will be included

A complete application includes:

Application Form

Authorization Forms: **1. General Authorization Form** **2. Sanford Authorization Form**

Applicants need to complete the Sanford Authorization Form if their medical provider is from Sanford in addition to the General Authorization Form.

Send Completed Applications to: MATBUS, 650 23rd St. N. Fargo ND 58102

or Fax: 701-241-8558

Please contact us if you have any questions or need help completing the application at 701-241-8140, TDD/Relay 7-1-1

Please print your answers to the following questions

1. **Are you applying for Paratransit eligibility?** Yes No

Paratransit eligibility automatically includes discount fare on the MATBUS fixed route. If you only want to apply for discount fare due to a disability or age, please complete the application for discount fare.

2. **Last Name**

First Name **Middle Initial**

3. **Address**

Pick-up location Instructions

Skilled Nursing Home Resident? Yes No

City **State** **Zip**

4. **Phone** **Gender** Male Female

5. **Date of Birth**

6. **List the name of one person or agency we may contact in case of an emergency**

Name **Agency**

Phone Day Evening

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 MATBUS 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, and be able to navigate the system (recognize destinations, understand transfers, distinguish between vehicles). Yes No Sometimes

11. How does this disability prevent you from using MATBUS Fixed Route Bus Service? If you answered “yes” or “sometimes” in question 10, please explain.

12. Do you need to bring a Personal Care Attendant (PCA) to assist you when you travel? No Yes Sometimes (explain)

13. Will you *regularly* need the driver to help you to/from the first door of your pick-up or drop-off? Yes No *If yes, the MAT Paratransit driver is only allowed to help through the first door of the building*

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

<input type="checkbox"/> electric wheelchair	<input type="checkbox"/> manual wheelchair
<input type="checkbox"/> scooter	<input type="checkbox"/> walker
<input type="checkbox"/> cane	<input type="checkbox"/> crutches
<input type="checkbox"/> guide animal	<input type="checkbox"/> oxygen tank
<input type="checkbox"/> other <input type="text"/>	

15. If you use a mobility device, is the combined weight of you and the wheelchair/scooter more than 800 pounds? Yes No

16. If you use an electric wheelchair, can you operate the controls yourself? Yes No *If not, the passenger is responsible for bringing a PCA on MATBUS and MAT Paratransit. The driver is not allowed to operate controls of an electric wheelchair.*

17. Are you capable of traveling in a vehicle with strangers without supervision for up to an hour? Yes No

If not, the passenger is responsible for bringing a PCA on MATBUS and MAT Paratransit. The driver does not provide supervision, direct a passenger unable to travel independently or ensure a passenger is not left alone at the destination.

18. Does the weather and/or environment impact your ability to use MATBUS?

Yes No If Yes, check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Temperatures above 85 degrees | <input type="checkbox"/> Temperatures below 32 degrees |
| <input type="checkbox"/> Snow and ice | <input type="checkbox"/> Unsafe street crossing |
| <input type="checkbox"/> Hours of darkness | <input type="checkbox"/> Uneven pavement or surfaces |
| <input type="checkbox"/> Other | <input type="checkbox"/> |

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

Yes No Sometimes

If you answered "NO" to Question 19, skip to Question 23

20. 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)

1/2 mile (about 6 blocks)

Yes No Sometimes (explain)

3/4 mile (about 9 blocks)

Yes No Sometimes (explain)

21. MATBUS fixed route buses and paratransit vans all have ramps or lifts. Do you require a ramp or lift instead of stairs to enter a vehicle?

Yes No Sometimes

22. Can you wait outside without support for ten minutes?

Yes No Sometimes

23. Do you have a mental or psychological disability? Yes No

24. Do you have a sight impairment, or are legally blind? Yes No

If you answered "NO" to Questions 23 and 24, skip to Question 26

25. 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)

learn how to make a transfer to another bus?

Yes No Sometimes (explain)

Demonstrate personal safety skills? (e.g. dress for weather, stranger interaction)

Yes No Sometimes (explain)

26. Do you need the Paratransit brochure in an alternate format?

Large Print Audio Language other than English

27. If approved would you like to sign-up for trip reminders?

Email Phone Both Email and Phone

28. List the names of any people or agencies that may call to inquire about your ride, to schedule rides for you, or update your personal information.

It is the responsibility of the applicant or their guardian to update this information with MAT Paratransit.

Name/Agency

Name/Agency

29. I hereby certify the information given above is correct.

Signature

Date

30. If someone other than the person requesting MAT Paratransit completed this application, please complete the following:

Name Agency/Relationship to Applicant

Address

Cell Phone Work Phone

Signature Date

31. If we have questions on your application, we will contact you. Would you rather we contact the person/agency who filled out the application on your behalf listed above? Yes No

* By answering yes, you are authorizing MATBUS staff and the person listed above to discuss your medical information.

32. If approved, would you like to receive non-official correspondence such as newsletters and promotional information by email? Yes No

Official mail will still be sent by regular mail.

E-Mail

AUTHORIZATION FORM

Name of Applicant:

In order to allow MATBUS to evaluate your eligibility for MAT Paratransit 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 provided. If you do not allow MATBUS to contact your physician or other professional, we will not be able to process your request. Please include this Authorization Form completed by you with your application. **If you have a Sanford medical provider, please complete the Sanford authorization form provided.**

The person listed below is familiar with my disability and is authorized to complete the professional verification form that MATBUS requires to determine my qualifications for MAT Paratransit for persons with disabilities. Once this information is provided to MATBUS, 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

Work Phone FAX

The application process can go faster if the professional's fax number is available.

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

Signature of Applicant

Date

NOTE: Any medical fees associated with providing this information are the responsibility of the applicant or client, and not the Cities of Fargo or Moorhead or MATBUS.



Authorization for Disclosure of Protected Health Information

Internal use only Sanford Health MRN	Patient Name: _____ Date of Birth: _____ Full Address: _____ Phone Number: _____ Maiden/Previous Names _____
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Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility: Sanford Health Systems
Address: PO Box MC
City, State, Zip: Fargo, ND 58122
Phone: _____

Release Information To:

Name/Facility: Metro Area Transit
Address: 650 23rd St. N.
City, State, Zip: Fargo, ND 58102
Phone: 701-235-4464

Purpose of Release:

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Personal
<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Application for Insurance	<input checked="" type="checkbox"/> Other: <u>At my request</u>	

Delivery Method: Date information desired by: ASAP

Release Format:	
<input type="checkbox"/> Paper	<input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input checked="" type="checkbox"/> Fax (as appropriate) Fax #: <u>701-241-8558</u>
<input type="checkbox"/> USB	<input type="checkbox"/> Mail <input type="checkbox"/> Pick Up
<input type="checkbox"/> Electronic via My Sanford Chart Patient Portal	
<input type="checkbox"/> Release to ALL My Sanford Chart Proxies	

Information to be Released:

Service Dates: From: _____ To: _____	OR <input type="checkbox"/> all future records until this authorization expires
NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____	
<input type="checkbox"/> Abstract (history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> ER Records <input type="checkbox"/> History & Physical <input type="checkbox"/> Clinic Visit Notes
<input type="checkbox"/> Psychological Evals/Assmts	<input type="checkbox"/> EKG/Cardiology Reports <input type="checkbox"/> Immunization Records <input type="checkbox"/> Operative Reports
<input type="checkbox"/> Lab / Pathology Reports	<input type="checkbox"/> Radiology Images <input type="checkbox"/> Radiology reports <input type="checkbox"/> Entire Medical Record (charge may apply)
<input type="checkbox"/> Billing Statements	<input checked="" type="checkbox"/> Other: <u>MATBUS Transportation Verification Form</u>
<input type="checkbox"/> Alcohol/Drug Treatment Records	_____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:
 X Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits

Signature (required)	Date Signed (required)
Relationship, If Not Patient	