MATBUS Discount Fare
for Persons with Disabilities

This application form is used by MATBUS to determine discount fare eligibility for persons with disabilities on MATBUS Fixed Route Bus System in the cities of Fargo/West Fargo, North Dakota and Moorhead/Dilworth, Minnesota.

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. **Some information requested on this application is optional, this includes date of birth and gender and is not used as a basis for determining eligibility for discount fare.**

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 discount-fare on MATBUS fixed route due to a disability?** Yes ❑ No ❑
   If you want to apply for MAT Paratransit service for people who are unable to use MATBUS independently due to a disability, please complete the Paratransit application form. This form is for discount-fare on the fixed route only.

2. **Does this disability prevent you from using MATBUS Fixed Route Bus Service independently?** For instance: to use Fixed Route Services, you may need to travel up to 1/4 mile (3 blocks) to a bus stop, wait outside for up to 10 minutes, and be able to navigate the city (recognize destinations, understand transfers, distinguish between vehicles). Yes ❑ No ❑
   (If Yes, or sometimes please complete the Paratransit application)

3. **Is this disability temporary?** Yes ❑ No ❑
   (If Yes, discount-fare is not provided for temporary disabilities)

4. **Last Name** _____

   First Name _____ **Middle Initial** _____

5. **Address** _____

   _____

   City _____ **State** _____ **Zip** _____

6. **Phone** _____ **Gender** Male ❑ Female ❑ (Optional)

7. **Date of Birth** ___/___/___ (Optional)

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

Name | Agency

Phone Day | Evening

9. **Do you have a Medicare card (red, white and blue card)?** Yes ❑ No ❑
(If yes, please include a copy of the card with this application.)

10. **Do you have a physical or mental impairment?** Physical ❑ Mental ❑ Both ❑

11. **Please explain how your disability impacts major life functions (e.g. work, walking, learning, hearing, speaking, seeing, breathing, caring for self, performing manual tasks)**

12. **I hereby certify the information given above is correct.**

Signature **Date**

13. **If someone other than the person requesting Discount Fare completed this application, please complete the following:**

Name | Agency/Relationship to Applicant

Address

Cell Phone | Work Phone

Signature | Date / /

14. **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.*

15. **If approved, would you like to opt in to receive non-official correspondence such as newsletters and promotional information by email?**

Yes ❑ No ❑

E-Mail

Under 49 USC 5307(d)(1)(D), recipients of Federal Transit Administration funding must ensure that "elderly and disabled individuals, or an individual presenting a Medicare card issued to that individual" are charged not more than half the peak fare during non-peak hours. While many transit operators extend this discount to include peak hour service, they are not required to do so. Title 49 of the United States Code, Chapter 53.

DISCOUNT FARE AUTHORIZATION FORM

Name of Applicant:

Date of Birth: (Optional) **Phone Number:**

Address:

PLEASE READ:

In order to allow MATBUS to evaluate your eligibility for Discount Fare for persons with disabilities, it is necessary for us to contact a physician or other professional with access to your medical records to confirm the information you provided on your application. 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, you will need to complete the Sanford Authorization form <u>in addition</u> to this form.**

The person listed below is familiar with my disability and is authorized to complete the Professional Verification form MATBUS requires to determine my qualifications for the Discount Fare 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

→ **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.

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 authorization. This authorization will expire automatically 12 months from the date of signature **OR** on (date/event)

Date:

Signature of Applicant or Authorized Representative

For use if you have a Sanford Provider

SANFORD HEALTH

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** _____

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:

☐Continuing Medical Care ☐Work Comp ☐Disability Determination ☐ Personal
☐Insurance Claim ☐Application for Insurance ☒Other: At my request

Delivery Method: **Date information desired by:** ASAP

Release Format:

☐ Paper ☐Mail ☐ Pick Up ☒ Fax *(as appropriate)* **Fax #:** 701-241-8558
☐ USB ☐Mail ☐ Pick Up
☐ Electronic via *My Sanford Chart* Patient Portal
☐Release to ALL My Sanford Chart Proxies

Information to be Released:

Service Dates: From: _____ To: _____ **OR** ☐ 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:_____

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

☐ Discharge Summary ☐ ER Records ☐ History & Physical ☐ Clinic Visit Notes
☐ Psychological Evals/Assmts ☐ EKG/Cardiology Reports ☐ Immunization Records ☐ Operative Reports
☐ Lab / Pathology Reports ☐ Radiology Images ☐ Radiology reports ☐ Entire Medical Record
☐ Billing Statements ☒ Other: MATBUS Transportation Verification Form (*charge may apply*)
☐ 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	