MAT Paratransit Application Form
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 <u>not</u> 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, by a date 21 days following the submission of a complete application, if no determination of eligibility, the applicant shall be treated as eligible and provided service until and unless MATBUS denies the application. If Paratransit eligibility is denied, the reason for the finding will be included, in a letter along with a description of the appeals process.

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

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 option 3, TDD/Relay 7-1-1 or paratransit@matbus.com

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 ❑ (Optional)

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

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.)**

- ❑ electric wheelchair
- ❑ manual wheelchair
- ❑ scooter
- ❑ walker
- ❑ cane
- ❑ crutches
- ❑ guide animal
- ❑ oxygen tank
- ❑ other

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 no, 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:

- ❑ Temperatures above 85 degrees
- ❑ Temperatures below 32 degrees
- ❑ Snow and ice
- ❑ Unsafe street crossing
- ❑ Hours of darkness
- ❑ Uneven pavement or surfaces
- ❑ Other

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 21

20. **Can you travel the following distance outside *without* the assistance of another person? <u>Travel includes using mobility aids</u> 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. **Are you able to step up onto the stairs or do you require a lift instead of stairs to enter the paratransit vehicle?** ***(The stairs for the Paratransit vehicle are 10 1/2 inches high.)***

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. **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

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

Signature **Date**

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

Name Agency/Relationship to Applicant

Address

Phone Work Phone

Signature Date / /

30. **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.*

MAT PARATRANSIT AUTHORIZATION FORM

Name of Applicant:

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

Address:

PLEASE READ:

In order to allow MATBUS to evaluate your eligibility for MAT Paratransit 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 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

→ **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	