PROFESSIONAL VERIFICATION FORM

CIL STAFF:

Part 1 Disability Verification:

(To be completed by a physician, social worker, healthcare professional, or rehabilitation professional.)

YES	NO	
☐	☐	Does this patient have a disability? If YES please provide **diagnosis/description** below.
		_____
		_____
☐	☐	If disability is cognitive or psychiatric in nature, please provide DSM-V diagnosis.
		_____
		_____
☐	☐	Does this person travel with a comfort animal?
☐	☐	Does the person take medication that is contraindicated by exposure to direct sunlight and/or heat?
☐	☐	Does this patient have a visual impairment? (Please provide visual acuity) ☐/☐
☐	☐	Does this person travel with a service animal?

PLEASE PROVIDE DETAILS HERE.

Part 2 Key Functional Ability: This information will help determine eligibility.

YES	NO	
☐	☐	Can the applicant get on/off the bus and make transfers?
☐	☐	Is their mobility or endurance impaired in any way? Explain: _____
		_____
☐	☐	Can the applicant travel independently, read a schedule or recognize landmarks?
☐	☐	Does the person have difficulty being around other people ? (PTSD, Anxiety, Mood Disorder)

Part 3 Assistive Devices & Equipment:

What type of mobility aid does this person use to travel within the community? *(Check all that apply)*

- ☐ Manual Wheelchair
- ☐ Power Wheelchair
- ☐ Cane
- ☐ Walker
- ☐ Oxygen
- ☐ Other

If this patient is using a wheelchair/scooter, please provide total combined weight of person and mobility device. → _____ **Lbs.**

Part 4 Signatures:

Health Care Professional Name and Title: _____

Business Address: _____ City/State Zip Code: _____

Telephone Number: ( ) _____

Signed: _____ Date: _____

PLEASE COMPLETE, DATE, AND SIGN HERE.

I authorize the above professional to furnish RTS and the Center for Independent Living with information necessary to certify my eligibility:

Patient/Applicant's Name: _____

Last 4 of Social: _____ Date of Birth: _____

APPLICANT Signature: _____ Date: _____

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