Center for Independent Living of North Central Florida

A 501 (c)3 Private Not-For-Profit Organization
Serving people with disAbilities for more than 30 years
www.cilncf.org

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Dear Health Care Provider,

Your patient is applying for ADA Paratransit service through the Center for Independent Living (CIL). It is a requirement of the application that we obtain a professional verification form verifying that this individual has a disability. In order to be eligible for this service, the individual must have a disability and the disability must impede his or her ability to use the RTS fixed route system.

The Center for Independent Living is requesting that you provide verification of disability for your patient within 14 business days upon receipt of this form. Federal regulation of this program requires that eligibility be determined within a finite period of time. Therefore, your expeditious attention to this matter would be greatly appreciated. Please complete the attached Professional Verification form and fax it to (352) 372-3443. If you have any questions regarding this form, please call Mark Mayfield, Consumer Transportation Advocate at the Center for Independent Living at (352) 378-7474.

Should you believe that this individual is not eligible for this service based on the criteria mentioned above, please indicate that in Part 1 of the form as well. Your prompt attention to this form will ensure that your patient receives the transportation options needed to function independently within the community.

Thank you,

Mark V. Mayfield
Consumer Transportation Advocate
Center for Independent Living of North Central Florida

PROFESSIONAL VERIFICATION FORM

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 in the space below. ________________
☐	☐	If disability is cognitive or psychiatric in nature, please provide DSM-IV 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) [/]

Part 2 Key Functional Ability:

Please describe how this person's disability prevents them from using the regular bus system (i.e. Can the applicant get on/off the bus, is the applicant capable of making a transfer, is their mobility or endurance impaired in any way, can the applicant travel independently, read a schedule or recognize landmarks.

____

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: ________________

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: ________________
Social Security Number: ________________ Date of Birth: ________________
APPLICANT Signature: ________________ Date: ________________