

Attachment A

PROFESSIONAL VERIFICATION OF DISABILITY STATUS

I, _____ agree to the release of the medical information disclosed on this form to the Santa Cruz Metropolitan Transit District for the purpose of METRO Discount Fare eligibility.

INDIVIDUAL'S SIGNATURE: _____ **Date:** _____

Date of Birth: _____

*This portion of form to be completed by a **Licensed Professional** as described in Regulation #AR-1028, Section 4.03 (i.e.: licensed physician, chiropractor, podiatrist, optometrist, audiologist, clinical psychologist, marriage & family counselor, as appropriate, based on disability category).

PROFESSIONAL VERIFICATION:

The above named individual has requested a Discounted Fare from Santa Cruz METRO Transit District. By my signature, I certify that the information below is true and correct. **I have reviewed the eligibility criteria as outlined in Regulation #AR-1028 - Section IV re: Eligibility and determined that my client is eligible for this program.**

The individual identified above is eligible for a discounted fare, due to his/her illness, injury, or incapacity, as listed below: (Check all that apply)

- The above named individual is a person who by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability (including, any individual who is a wheelchair user or has semi-ambulatory capabilities), is unable, without special facilities, planning, or design, to utilize public transportation facilities and services as effectively as a person who is not so affected. (***See Section 4.04 for Category descriptions**). Please list the Category disability that this individual has _____.
- The Disability is permanent.
- The disability is not permanent and will expire on _____.
- The above named individual requires the use of a **Personal Care Attendant (PCA)**.
How long do you anticipate the need for a PCA?
 Permanent; or Temporary

(Specify expiration date)

Signature of Licensed Professional: _____ **Date:** _____

Print Name of Licensed Professional: _____

Professional Title: _____ **License Number:** _____

Address: _____

Telephone: () _____