

## **CARE-A-VAN ELIGIBILITY CENTER** HEALTHCARE PROVIDER VERIFICATION FORM PART B 1617 Wilcox Blvd Chattanooga, TN 37406

Applicant Name \_\_\_\_\_

DOB

## Healthcare Provider Verification – To be completed by a Healthcare professional

Please note the following are some of the licensed health care professionals that are authorized to fill out the application:

- Physician (MD or DO)
  - Registered Nurse
- Psychiatrist
- Ophthalmologist Physical Therapist
  Occupational Therapist
- Psychologist
- Optometrist (visual disabilities only)
- Other licensed provider familiar with the applicant's condition

\*\*Please Fax (423)698-8555, email: CAVEligibility@gocarta.org or Mail directly to CARTA Care-a-Van, 1617 Wilcox Blvd. Chattanooga, TN 37406\*\*

Please complete the section below. The information that you provide must be based solely upon the applicant having an actual physical or cognitive limitation, which prevents the use of our fixed route bus service. The diagnosis of a potentially limiting illness or condition is not sufficient determination for paratransit services.

- 1. What is the applicant's disability?
- 2. How does the condition functionally prevent the applicant from using regular bus service?
- 3. If temporary, what is the duration?
- 4. Does this individual use a mobility aid?  $\Box$  Yes  $\Box$  No If yes, what type of mobility aid do they use?
- 5. If this individual is currently taking prescribed medication(s), does this medication enhance or diminish the individual's functional ability to travel independently? Please explain:

6.	Are any of the following affected by the individual's disability? (Check all that apply)			
	□ Orientation	□Monitoring time	□Gait or balance	
	$\Box$ Problem solving	□Judgment	□Inconsistent performance	
	□Short-term memory			
	Inappropriate social behavior		Ç ,	
	Other (please explain)			
7.	Please feel free to let us know if you have any other comments:			
Signature of Medical Professional			Date	
Professional License #		State Issued		
Print I	Name			
	255			
City _		State	Zip Code	
Phone #		Extension	_ Extension	
Conta	act person			

I acknowledge the purpose of this application is to determine my ability to use transit and paratransit services. I understand that the staff of the Chattanooga Area Regional Transportation Authority (CARTA) and CARTA Care-a-Van may need to discuss my application to obtain additional information. I have been truthful in answering all these questions and my information may be verified. I authorize the health care professional, including psychiatrists or psychologists, designated in this application to release and provide CARTA and CARTA Care-a-Van, or its representatives, any additional information that may be required to complete or clarify this application. I agree that, when possible, I will travel to the nearest location that can serve my needs and understand that this will allow CARTA to most efficiently serve the needs of the community.

I certify that I am legally licensed and am currently treating \_\_\_\_\_\_. The above information I have provided hereto is a fair representation of this applicant's disability(s) or health condition(s) and is true and correct under penalty of perjury according to the laws of the State of Tennessee. I understand the information provided will be used for the sole purpose of determining the applicant's eligibility for paratransit service. I also agree that CARTA may contact me for clarification of any information I have provided and that I will reply with good faith. I understand the information contained herein is true and correct to the best of my knowledge and ability. Any falsification could result in the client's loss of paratransit service.

Signature: \_\_\_\_\_

Date: