CIL STAFF: ____

EMPOWERING INDIVIDUALS WITH DISABILITIES

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/description** below.
☐	☐	If disability is cognitive or psychiatric in nature, please provide DSM-V diagnosis.
☐	☐	Does this person travel with a service 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)

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: ____

Signature: ____ 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: ____ DOB: ____ Phone # : ____

Consumer Signature 6: ____ Consumer Date 6: ____

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