Area Regional Transit Paratransit Eligibility Medical Verification Forms

Please ask your Florida Licensed/Certified Health Care Provider to complete the medical form that best describes your need for Paratransit services.

Note to Medical Provider: By completing and signing the medical documents, you certify the truth and accuracy of the information provided on the application, to the best of your professional knowledge. The Americans with Disabilities Act of 1990 requires ART to provide services to persons who are unable to use the fixed route bus system due to a disability. The information you provide will allow ART to make an appropriate evaluation of your client's eligibility.

To qualify for Paratransit service, an individual must meet the criteria as outlined in one of the following categories:

Category 1: Individuals who, because of physical or mental impairment (including visual impairments) and without the assistance of another individual (except the operator) cannot board, ride, or disembark from an accessible transit vehicle.

Category 2: Individuals who can independently use accessible vehicles, but none are available on their route.

Category 3: Individuals who have a specific impairment-related condition that prevents them from independently getting to/from a stop.

Located at www.slcart.org, you may submit additional completed verification forms as applicable:

Form A - General Medical

Form B - Vision

Form C - Epilepsy or Seizure Disorders

Form D - Cognitive or Mental Health Conditions

ATTACH A COPY OF YOUR VALID FLORIDA DRIVER'S LICENSE/ID OR CURRENT GOVERNMENT-ISSUED ID WITH THIS APPLICATION.

Fax: 772-462-1684 art area regional transit Email: rideslc@stlucieco.org

Area Regional Transit Paratransit Eligibility

Form D: Cognitive or Mental Health Conditions

To be completed by a Licensed Health Care Provider:

Applicant's Name:

Date of Birth:

1. Please state the applicant's diagnosis from the DSM.

2. Date of onset?

3. Check any of the following that pertain to the individual's disability:

	Orientation		Concentration		Monitoring time
	Problem-solving		Coping Skills		Judgment
	Short term memory		Communication		Gait or balance

I certify that the information provided above is correct:

Signature of Licensed Health Care Provider

Date

Print your contact information below:

Name

Board cert # or License #

Phone#

Fax#

Business address: