

REQUEST for CERTIFICATION of Americans with Disabilities Act
(ADA Paratransit ELIGIBILITY)

VERIFICATION is needed to certify that you are unable to use the regular fixed-route Bus Service and need to use specialized "curb-to-curb" paratransit service. Evaluation of your Request will begin as soon as the form is completed and received. The information obtained in this request will only be used by the City of Fond du Lac and/or the Fond du Lac County for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas and WILL NOT BE shared with any other person or agency. Return completed, signed form to FOND DU LAC COUNTY SENIOR SERVICES DEPT. - ADA, 160 S. MACY STREET, FOND DU LAC, WI 54935. You will be notified of our determination within 14-21 days after we receive your Request. If you have any question, call 929-3110, Fond du Lac County Senior Services.

1) Name _____ Date of Birth _____
Address _____
State _____ Zip _____ Telephone # _____ Home _____
Work _____

2) The DISABILITY which prevents me from using the City "Bus service" is:

_____ Permanent _____ Temporary (If temporary, expected duration _____)

3) How does the disability prevent you from using the City "bus service" ? (Explain completely)

4) How far can you walk without the assistance of another person?
_____ 1 block _____ 2-3 blocks _____ 4-9 blocks

5) Is your ability to travel affected by extremes in the weather? _____ Yes _____ No
If yes, please explain: _____

6) Do you require a Personal Care Attendant: _____ Yes _____ No

7) Other effects or disability of which we need to be aware: _____

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip request can be made by the City of Fond du Lac/Fond du Lac County.

8) Do you use any of the following aids to MOBILITY? CHECK ALL THAT APPLY
_____ manual wheelchair _____ electric wheelchair _____ powered scooter
_____ cane _____ crutches _____ guide dog

9) I here by CERTIFY that the information given above is correct:

Signature

Date

Continued on the Reverse Side.

- 10) If this REQUEST FOR CERTIFICATION has been completed by someone other than the person needing service, that person must complete/sign the following:

Name _____ Telephone # _____ Home
 Address _____ Work
 State _____ Zip _____ Reason _____

 Signature Date

- 11) In order for the City of Fond du Lac/Fond du Lac County to evaluate the request, it may be necessary to contact a physician or other professional to confirm the provided information. Please complete the following information and authorization form.

The following ___ Physician ___ Health Care Professional ___ Rehabilitation Professional is familiar with my DISABILITY and is authorized to provide required information to the City of Fond du Lac/Fond du Lac County to complete the REQUEST for CERTIFICATION:

Name _____
 Address _____
 State _____ Zip _____

 Signature of Person Requesting Certification

 Date

OFFICE USE (only) Date in: _____ (received). Date out: _____ (21 days Max.).

_____ 's REQUEST is: _____ approved _____ not approved
 _____ Level _____ Coding + # _____

Certifier

Date

CODING:

W - wheelchair/walker/brace/other
 WT - wheelchair/walker/brace/other (TEMPORARY)

P - physical disability
 PT - physical disability (TEMPORARY)

D - developmental disability

M - psychiatric disability

C - climate sensitivity
 CS - climate sensitivity (seasonal TEMPORARY)

E - escort (one-to-one/automobile) (TEMPORARY)
 ET - escort (one-to-one/automobile) (TEMPORARY)

RETURN TO:

Fond du Lac County
 Senior Services Dept. - ADA
 160 S. Macy Street
 Fond du Lac, WI 54935

Direct questions to 929-3110, Fond du Lac County, Senior Services Dept.

**WISCONSIN MEDICAID
CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION**

Instructions: Type or print clearly. All areas of this form must be completed and signed by a medical care provider (evaluator) to verify the need for specialized medical vehicle (SMV) transportation. Only a physician, physician assistant, nurse midwife, or nurse practitioner may be an evaluator and sign this form. Refer to the Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions, F-1197A, for information on completing this form.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Member Identification Number	3. Member's Date of Birth (MM/DD/YY) (Optional)
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SECTION II — ELIGIBILITY FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

4. Does the member have a physical / mental impairment that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle?
- If "no," then **STOP** here. Do **not** complete or sign this form. Instead, refer the member to the Medicaid transportation coordinator at his or her local county or tribal agency.
- If "yes," then complete Sections III and IV of this form.

SECTION III — DIAGNOSIS INFORMATION AND VERIFICATION OF MEDICAL CONDITION

5. I have evaluated this member and certify that he or she is one of the following. (Refer to the completion instructions of this form for definitions of indefinitely and temporarily disabled.) (Check one.)
- Indefinitely disabled. This form is valid for three years (36 months) from the date signed by the medical care provider.
 - Legally blind. This form is valid for three years (36 months) from the date signed by the medical care provider.
 - Temporarily disabled. This form is valid for no more than 90 days from the date signed by the medical care provider. (This certification of need may be renewed after 90 days, if necessary.)
- If less than 90 days, state expected duration of disability: _____ days

6. Does the member require the use of a wheelchair or scooter?
- Yes No

7. The evaluating medical provider is required to explain in the space provided why the member's physical / mental condition requires transportation in an SMV and why the member cannot access mass transit, taxi, or a private vehicle. Include the diagnosis, if possible.

SECTION IV — MEDICAL CARE PROVIDER (EVALUATOR) INFORMATION

I, the medical provider (physician, physician assistant, nurse midwife, or nurse practitioner), have evaluated this member and certify that he or she has a condition that contraindicates safe travel by common carrier, such as private vehicles or mass-transit services, and requires the use of an SMV for transportation to receive medical services.

8. SIGNATURE — Evaluator	9. Date Signed — Evaluator	
10. Name — Evaluator (Print)	11. Position Title — Evaluator	
12. National Provider Identifier	13. Taxonomy Number (Optional)	14. Practice Location ZIP+4 Code (Optional)

