RFTA Select Discount Card - Health Care Professional Certification

The Health Care Professional Certification form **must be completed by a licensed or certified health care professional** and must be received by the RFTA within 60 days of the health care professional's signature.

Please print legibly or type and complete all information.

Name of applicant: _____

Applicant date of birth (MM/DD/YYYY): _____ Applicant phone: _____

Applicant email: _____

Applicant mailing address: _____

Name of Health Care Professional: _____

Licensure title: _____ Specialty: _____

License number: _____ State issued: _____

Business address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email address: _____

The following must be completed by the Health Care Professional:

1. What is the applicant's disability?

Use category number(s) from Guidelines (page 2): _____

Please specify diagnosis:

_____

_____

2. How does the disability cause the applicant difficulty accessing transportation?

_____

_____

3. Expected duration of disability (please select only one of the three options below):

- ☐ Short-term disability (i.e. conditions with potential for improvement within 1 year)
- ☐ Long-term disability (i.e. conditions with potential for improvement in greater than 1 year)
- ☐ Permanent disability (e.g. conditions with no expectation of improvement)

4. I certify that the information I have provided above about this RFTA Select Discount Card applicant is correct to the best of my knowledge:

_____

Health Care Professional's Signature **Date**

Note: *The RFTA reserves the right to ask to see an original signature of the applicant's health care professional.*

Guidelines for Health Care Professionals

Please use the categories below to complete the response to “What is the applicant’s disability?” of the Health Care Professional Certification form.

1. **DISABILITIES REQUIRING WHEELED MOBILITY** such as the use of a wheelchair, scooter, etc.
2. **SEMI-AMBULATORY DISABILITIES** that cause an individual to walk with difficulty or insecurity, and that may or may not require the use of leg braces, walker, cane, crutches, or other mobility device.
3. **SEVERE NEUROMUSCULAR / MUSCULOSKELETAL CONDITIONS** such as muscular dystrophy, osteogenesis imperfecta, or arthritis where functional capacity is limited in ability to perform activities of daily living.
4. **AMPUTATION OF AN EXTREMITY:** Please specify which limb(s) are affected.
5. **SEVERE EFFECTS FROM CVA (STROKE)** including conditions where there is a functional motor deficit affecting any two limbs or ataxia 4 months post-CVA.
6. **SEVERE PULMONARY CONDITIONS (obstructions/ restrictions)** that affect mobility, including those that result in dyspnea during activities of daily living; while climbing a flight of ordinary stairs or walking 100 yards; with the slightest exertion or even at rest.
7. **SEVERE CARDIAC CONDITIONS** including those that result in moderate or marked restriction in ordinary physical activity, and that may cause fatigue, palpitations, dyspnea, or angina pain while climbing a flight of ordinary stairs or walking one or more level blocks, with the slightest exertion or even at rest.
8. **IMMUNOCOMPROMISED** individuals, due to conditions such as HIV/AIDS; cancer or treatment for cancer; organ or bone marrow transplant; or chronic diseases such as lupus or rheumatoid arthritis.
9. **LOW VISION** where an individual has a visual acuity in the better eye, after correction, of 20/70 or less but is not legally blind.
10. **LEGALLY BLIND** where an individual has a visual acuity in the better eye, after correction, of 20/200 or less; or where the peripheral field is 10º radius or less, regardless of visual acuity.
11. **KIDNEY DIALYSIS TREATMENT.**
12. **DEAF/HARD OF HEARING.**
13. **COORDINATION DISABILITIES** where there is a functional motor deficit in any two limbs or manifestations that significantly reduce mobility, coordination, and/or perception.
14. **INTELLECTUAL DISABILITY.**
15. **EPILEPSY (CONVULSIVE DISORDER).**
16. **AUTISM:** Please describe nature and extent of disability.
17. **NEUROLOGICAL DISABILITIES** affecting learning, perceptual, and behavioral functioning. Please include nature of condition and etiology.
18. **PSYCHIATRIC DISABILITIES** where there is a long-term mental illness that:
    - includes a substantial disorder of thought, memory, perception, or orientation, or
    - significantly impairs judgment, behavior, capacity to recognize reality, or
    - significantly impacts ability to meet ordinary/independent life support needs of food, shelter, clothing, management of finances, and health care.