

**Authorization Form for Disclosure  
of Protected Health Information**

I, \_\_\_\_\_, authorize:

*(Print name of applicant)*

\_\_\_\_\_, who is completing the Physician Verification Form

*(Print name of Physician)*

on my behalf, to release this information about my disability and abilities to representatives of the Redding Area Bus Authority (RABA) for their review, as well as any supporting or other pertinent information about my health or medical condition to assist RABA solely for the purpose of determining eligibility for RABA Demand Response Americans with Disabilities Act (ADA) paratransit service. I understand that all medical information about my disability will be kept strictly confidential.

**I understand that I do not have to sign this authorization in order to be considered for services, but I understand that no weight will be given to medical conditions claimed which cannot be verified.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I have the right to revoke this authorization in writing except to the extent that RABA has acted in reliance upon this authorization. My written revocation must be submitted to RABA at 777 Cypress Avenue, Redding, CA.

\_\_\_\_\_  
Signature of Applicant or Legal Guardian

\_\_\_\_\_  
Date

(NOTE: May be signed by a legal guardian with power of attorney only if documentation showing your legal authority to act and sign on applicant's behalf is also provided.)

Applicant/Guardian must be provided with a copy of this authorization form.

**Attention Physician:**

Please return a copy of this signed authorization with the completed Physician Verification Form.



**DEMAND RESPONSE**

**PHYSICIAN VERIFICATION FORM**

Dear Physician:

You are being asked to provide information regarding the applicant's impairments as part of his/her application for RABA Demand Response service. RABA Demand Response is a specialized curb-to-curb transportation service provided as required by the Americans with Disabilities Act (ADA). The Demand Response service is provided to people who, due to an impairment, are prevented from using fixed route transit, like RABA's regular bus service. Eligibility for Demand Response service is not granted because a person finds it difficult or uncomfortable to get to and from bus stops or to ride the bus. Likewise, age, apart from disability, does not confer eligibility. An applicant must be **UNABLE** to utilize the fixed route bus system.

RABA will use the information you provide as part of our process to determine if applicants are prevented from using regular transit or if they have the functional ability to use the fixed route bus. If you have questions about the process, please call our Certification Office at (530) 225-4170.

**COMPLETE THIS SECTION FOR ALL APPLICANTS**

Applicant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. In what capacity do you know this applicant? \_\_\_\_\_

2. When was your last evaluation of this applicant? \_\_\_\_\_

3. Can this applicant travel alone outside the home? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_

4. Does this person take medications that would affect his/her ability to travel on public transportation?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain \_\_\_\_\_

5. If traveling alone, does the applicant have the ability to:

- Wait outside at a bus stop for 10 to 15 minutes? Yes\_\_\_\_ No\_\_\_\_ Don't Know \_\_\_\_
- Grasp handles, coins, tickets? Yes\_\_\_\_ No\_\_\_\_ Don't Know \_\_\_\_
- Stand and maintain balance on a moving bus if holding a railing/pole? Yes\_\_\_\_ No\_\_\_\_ Don't Know \_\_\_\_
- Cross streets safely and find a bus? Yes\_\_\_\_ No\_\_\_\_ Don't Know \_\_\_\_
- Understand and follow a bus schedule? Yes\_\_\_\_ No\_\_\_\_ Don't Know \_\_\_\_
- Communicate needs? Yes\_\_\_\_ No\_\_\_\_ Don't Know \_\_\_\_

**The sections on the following pages pertain to specific types of conditions or impairments. Please complete *ONLY* those sections that apply to this applicant.**

**COMPLETE THE FOLLOWING FOR APPLICANTS WITH  
MOBILITY IMPAIRMENTS**

1. Briefly describe the impairment or condition and any corresponding limitations: \_\_\_\_\_  
\_\_\_\_\_
2. Does this person use a mobility aid? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, circle those used:  
Manual Wheelchair / Power Wheelchair / Cane / Walker / Scooter / Crutches / Leg Braces  
Other: \_\_\_\_\_
3. How far can the applicant walk with mobility aid(s), or travel in a wheelchair?  
Less than 1 block \_\_\_\_ 1 to 2 blocks \_\_\_\_ 3 to 6 blocks \_\_\_\_ 7 or more blocks \_\_\_\_ Don't Know \_\_\_\_
4. Is this condition temporary? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
If yes, how long will this condition last? \_\_\_\_\_

**COMPLETE THE FOLLOWING FOR APPLICANTS WITH  
VISUAL IMPAIRMENTS**

1. Briefly describe the visual impairment and any corresponding limitations: \_\_\_\_\_  
\_\_\_\_\_
2. Does this visual impairments affect this person's ability to travel on public transit: Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_
3. Is this condition temporary? Yes \_\_\_\_\_ No \_\_\_\_\_ Don't Know \_\_\_\_\_  
If yes, how long will this condition last? \_\_\_\_\_

**COMPLETE THE FOLLOWING FOR APPLICANTS  
WITH PSYCHIATRIC IMPAIRMENTS OR CONDITIONS**

1. Briefly describe the impairment or condition and any corresponding limitations: \_\_\_\_\_  
\_\_\_\_\_
2. Does this impairment or condition affect this person's ability to travel on public transit:  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_
3. Is this person a risk to others or themselves, especially when in close quarters?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_
4. Does this person demonstrate inappropriate social behavior (i.e., is he/she aggressive or overly friendly)?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_

**COMPLETE THE FOLLOWING FOR APPLICANTS WITH COGNITIVE IMPAIRMENTS,  
DEVELOPMENTAL DISABILITIES, NEUROLOGICAL IMPAIRMENTS, OR HEAD INJURIES**

1. Please describe the impairment and any corresponding limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Does this impairment impact this person's ability to use public transit? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
3. Does the applicant experience seizures? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type of seizures and how often? \_\_\_\_\_
4. Does this person demonstrate inappropriate social behavior (i.e., is he/she aggressive or overly friendly)?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN CERTIFICATION**

Does the patient's impairment prevent him/her from riding the Fixed Route System? Yes  No   
By my signature, I certify that this information is true and correct. I understand that the falsification of the information may result in denial of service to the applicant. I understand that all information will be kept confidential.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Print Name \_\_\_\_\_ California License # \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

**RETURN THE COMPLETED FORM TO  
RABA DEMAND RESPONSE**

Fax form to:  
(530) 245-7024

Or mail form to:  
RABA  
PO Box 496071  
777 Cypress Avenue  
Redding, CA 96049-6071