THIS FORM MUST BE COMPLETED BY A MEDICAL PROFESSIONAL

CICOA
Aging & In-Home Solutions
A member of the 2-1-1 connect Alliance

Medical/Professional Verification
For My Freedom Program (My Freedom Application & Medical Verification Form is required in order to begin processing)

(Not a request for copies of medical records)

Dear Health Care Professional:

One of your clients has requested an assessment for use of transportation via the My Freedom Program. We need verification about **the client's condition or disability and how this impacts their functioning when accessing and utilizing public transportation.** Please note that the following factors **do not** automatically qualify a person for the My Freedom Program: (a) disability, (b) distance to and from a bus stop, (c) inability to drive, (d) inconvenience, and/or (e) discomfort. The disability must PREVENT travel within a public transportation system.

When completed, please fax this form to the CICOA My Freedom Program
FAX NUMBER (317) 803-6151 or have the applicant turn it in with their application.

Applicant's Name: _____ Date of Birth: _____
Address: _____
Applicant's Phone Number: _____

1. In what capacity do you know this applicant? _____
How long have you known this applicant? _____

2. Please describe the applicant's condition(s), which affect ability to travel in the community.

Check Relevant Type(s) of Conditions	**List Relevant Diagnoses** DSM-5 code(s):	**Date of Onset**	**Prognosis (if temporary, state length)**
___ Physical Disability			
___ Intellectual Disability			
___ Cognitive Disability			
___ Mental Illness			
___ Vision Impairment/ Blindness			
please identify condition: ___ Other: _____			

3. Does the applicant require dialysis treatment?
If so, please indicate the days of treatment: _____

4. Are any of the following affected by applicant's condition(s)? Check ALL that apply:

_____ Orientation
_____ Short term memory
_____ Long term memory
_____ Communication
_____ Gait or Balance
_____ Endurance
_____ Impulse Control
_____ Problem-solving
_____ Attention
_____ Time management
_____ Judgment
_____ Handling stress
_____ Interacting according to social customs
_____ Other _____

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5. What are the primary sensory, cognitive, and/or physical difficulties the applicant has with **getting to and from bus stops?** _____

_____

_____

6. What are the primary sensory, cognitive, and/or physical difficulties the applicant has with **getting on, riding, and getting off regular city buses**? _____

_____

_____

8. What are the primary sensory, cognitive, and/or physical difficulties the applicant has with **understanding, remembering, and "navigating" the system to ride regular city buses?**

_____

_____

_____

9. Additional Comments:

_____

_____

_____

I certify that the information contained herein is true and correct to the best of my knowledge and ability.

Signature: _____ Date: _____

Printed Name: _____

Professional Title: _____

Professional License, Registration or Certification Number: _____

Clinic/Agency: _____ Phone: _____

Address: _____ Fax: _____

_____

_____

Thank you for your time and input.

Way2Go Transportation Department
CICOA Aging & In-Home Solutions
8440 Woodfield Crossing Blvd Ste 175
Indianapolis, IN 46240
OFFICE: (317) 803-6153
FAX: (317) 803-6151

FOR OFFICE USE ONLY ELIGIBLE? Y N ID # _____

DATE RECEIVED: _____

APPLICATION RECEIVED? Y N DATE RECEIVED: _____

COMMENTS: