

**Section V: Professional Verification of Diagnosed Disability  
(Required to be completed by a health professional)**



A diagnosed disability does **not** determine eligibility for Metro’s Access Transportation program. Functional ability to use regular public transit as evaluated by King County Metro determines an applicant’s eligibility.

The ADA regulations state that persons are eligible for Access van service if, because of a disability or medical condition, they are physically or cognitively **prevented (not discomforted by or find difficult)** from independently using regular lift or ramp equipped bus service. Depending on their disability, people can be eligible sometimes, or all of the time. **Access eligibility is not based on the person’s lack of knowledge of bus service, distance from bus service, age, inability to drive, discomfort with riding the bus, language or cultural issues.**

**To The Applicant:** This page must be completed before returning your application to King County Metro. **If this page is not signed and completed by one of the professionals below, the application will be returned to you; this will delay your Access eligibility determination.** If you are not associated with any of the professionals below, please call King County Metro’s Access Transportation at 206-263-3113 (voice) or WA Relay: 711.

**V-A. To The Professional – check your professional title:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Physician/Doctor  | <input type="checkbox"/> Physical Therapist   | <input type="checkbox"/> Vocational Rehabilitation Counselor              |
| <input type="checkbox"/> Physician Assist. | <input type="checkbox"/> Occupational Therapist                                     | <input type="checkbox"/> Special Education Teacher                        |
| <input type="checkbox"/> RN or ARNP        | <input type="checkbox"/> Recreation Therapist CTRS/R (employed by medical facility) | <input type="checkbox"/> Case Resource Manager (employed by DSHS/DDD/AAA) |
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Certified Speech Therapist                                 | <input type="checkbox"/> MSW (employed by a medical facility)             |
| <input type="checkbox"/> Psychiatrist      | <input type="checkbox"/> Certified Orientation and Mobility Specialist              |   |
| <input type="checkbox"/> Psychologist      |   |   |

**V-B. Please List Applicant’s Diagnosed Disabilities (required, otherwise application is returned):**

\_\_\_\_\_

**V-C. Is this condition temporary?**  No  Yes, for:  4 mos  6 mos  9 mos  12 mos  
 Other \_\_\_\_\_

**V-D. This person**  is  is not...able to self-supervise daily activities.

**V-E. Last date of face-to-face contact with this applicant was** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ .

**V-F. Would you like us to contact you regarding this applicant?**  Not unless needed  Yes

I understand that I am only providing a disability diagnosis and that I am not making an Access Transportation eligibility determination. I understand that the determination for Metro’s Access Transportation program lies solely with King County Metro.

I certify under penalty of perjury under the laws of the State of Washington (RCW 9A.72. 030) that the diagnosis above is true and correct. Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**V-G. Professional's Signature** \_\_\_\_\_ **Title** \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Clinic/Agency \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Applicant’s Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_