JAMHI
Health & Wellness, Inc.
An NCADD Affiliate

Reentry Program Application

First Name: _____

Last Name: _____

Date of Birth: _____Phone:_____

SSN: _____

ACOMS: _____

Medicaid: _____

Prison Release Date? _____

Where are you currently living? _____

Will you be on Parole?

- Yes
- No

Will you be on Probation?

- Yes
- No

What is the name of your probation officer? _____

Was your crime a felony?

- Yes
- No

What do you need help with?

_____
_____
_____
_____
_____
_____
_____

JAMHI Health & Wellness, Inc.
An NCADD Affiliate

JAMHI Health & Wellness, Inc.

Salmon Creek Clinic
3406 Glacier Hwy
Juneau Alaska 99801
907-463-3303

Midtown Clinic
1944 Allen Court
Juneau, AK 99801
907-463-6882

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION

I, _____ , Date of Birth: _____
Name of Client

hereby authorize **JAMHI Health & Wellness, Inc. (JAMHI)** to exchange information/document(s) with/

between the following agency or person: **AK DOC & Probation and Parole**

ADDRESS: _____

PHONE # _____ FAX #: _____

INFORMATION TO BE RELEASED/RECEIVED: (Please check)

- X Behavioral Health / Substance Use Assessments
- X Psychiatric Assessments / Evaluations
- X Behavioral Health Treatment Plans
- X Medication List / Medication Management Notes
- X Functional Assessments
- ___ Redisclosure of third-party records on file at JAMHI for the purpose of payment, treatment and operations
- ___ Medical Records
- ___ Laboratory/Radiology
- ___ APA/Med 11/AD #2 Forms
- ___ Billing Records
- X Discharge Summary
- ___ Housing
- X Verification of Participation and/or Attendance
- X Other: **Verbal and/or written status update reports**

PURPOSE OF INFORMATION: (Please check)

- ___ Legal Use
- ___ Intake Information
- ___ Employment / Vocational Assistance
- X Coordination of Treatment
- ___ Benefits / Eligibility
- ___ Housing / Tenancy / Eligibility
- ___ Personal / Self
- ___ Other _____

By signing this form I understand that:

* I am authorizing the use and disclosure of my healthcare and/or other information described above; my authorization is voluntary.
* I may revoke this authorization at any time by notifying the individuals(s) or organization releasing this information in writing or verbally, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received.
* The individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable), or eligibility for benefits on whether I provide this authorization.
* The Protected Health Information (PHI) released may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment for substance use disorders. _____ **I do not want this information to be disclosed.**
* I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
* Requests for copies of medical records over ten (10) pages may be subject to copying fees.

DATE / EVENT:

This authorization expires on the following event: _____ or one (1) year from the date of signature if no other date or event is indicated.

_____
Signature of Client Date

_____
Signature of Authorized Representative (if required) Date
AND Description of Representative's Authority

_____
Signature of Witness (not required) Date

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (42 CFR, Part 2) prohibiting you from making any further disclosure of this information, without the specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

JAMHI Health & Wellness, Inc.
An NCADD Affiliate

JAMHI Health & Wellness, Inc.

Salmon Creek Clinic
3406 Glacier Hwy
Juneau Alaska 99801
907-463-3303

Midtown Clinic
1944 Allen Court
Juneau, AK 99801
907-463-6882

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION

I, _____ , Date of Birth: _____
Name of Client

hereby authorize **JAMHI Health & Wellness, Inc. (JAMHI)** to exchange information/document(s)

with/between the following agency or person: **AK DOC**

ADDRESS: _____

PHONE # _____ FAX #: _____

INFORMATION TO BE RELEASED/RECEIVED: (Please check)

X	Behavioral Health / Substance Use Assessments		Medical Records	X	Other: **Verbal and/or written status update reports**
X	Psychiatric Assessments / Evaluations		Laboratory/Radiology		
X	Behavioral Health Treatment Plans		APA/Med 11/AD #2 Forms		
X	Medication List / Medication Management Notes		Billing Records		
X	Functional Assessments	X	Discharge Summary		
	Redisclosure of third-party records on file at JAMHI for the purpose of payment, treatment and operations		Housing		
		X	Verification of Participation and/or Attendance		

PURPOSE OF INFORMATION: (Please check)

	Legal Use		Benefits / Eligibility
	Intake Information		Housing / Tenancy / Eligibility
	Employment / Vocational Assistance		Personal / Self
X	Coordination of Treatment		Other _____

By signing this form I understand that:

* I am authorizing the use and disclosure of my healthcare and/or other information described above; my authorization is voluntary.
* I may revoke this authorization at any time by notifying the individuals(s) or organization releasing this information in writing or verbally, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received.
* The individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable), or eligibility for benefits on whether I provide this authorization.
* The Protected Health Information (PHI) released may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment for substance use disorders. _____ **I do not want this information to be disclosed.**
* I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
* Requests for copies of medical records over ten (10) pages may be subject to copying fees.

DATE / EVENT:

This authorization expires on the following event: _____ or one (1) year from the date of signature if no other date or event is indicated.

_____
Signature of Client Date

_____
Signature of Authorized Representative (if required) Date
AND Description of Representative's Authority

_____
Signature of Witness (not required) Date

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (42 CFR, Part 2) prohibiting you from making any further disclosure of this information, without the specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

JAMHI Health & Wellness, Inc.

An NCADD Affiliate

Name: _____

Date: _____

ACOMS: _____

Reentry Behavioral Contract

Instructions:
Please read and initial each of the following, then sign and date this contract. You will need to agree to the following requirements in order to be admitted to the Alaska Community Reentry Program in the community of Juneau. This program is administered through JAMHI Health & Wellness Inc. The reentry program is 6 months in length and is a voluntary program designed to help you to reintegrate back into the community successfully.

1. _____ I agree to maintain sobriety while in the reentry program even if it is not a condition of my release. (This includes the use of marijuana, alcohol and any illegal substances.)
2. _____ I may be asked to submit a UA to confirm sobriety.
3. _____ If I have a relapse I will be required to complete a behavioral intervention contract with my case manager that outlines goals, current circumstances, solutions, plans, and responses. I will be required to follow this intervention plan or I may be discharged from the Reentry Case Management Program.
4. _____ I agree to follow all AKDOC institutional rules and/or probation/parole conditions.
5. _____ I understand that if I commit a new crime or probation/parole violation I may be discharged from the program.
6. _____ I will attend the reentry support group every week while I am in the first phase of the reentry program. (Thursday's at 9AM at JAMHI)
7. _____ I will attend all groups, classes, and individual sessions as required and outlined in my Reentry Transition Plans.
8. _____ I will complete all program assignments in a timely manner. If I do not understand the assignment, it is my responsibility to ask for help.
9. _____ I understand that staff will discuss my presenting Reentry Transition Plan issues/problems with me and my progress or lack of progress of applying my Plan Goals.
10. _____ I understand that change is an ongoing process and that sometimes change may be challenging.
11. _____ I understand that if I am not progressing in Reentry Case Management Program, my Case Manager may schedule a wrap-around meeting to discuss behavioral issues. The meeting may include my probation or parole officer and current providers, depending on the circumstances. At the end of the wrap-around meeting I will be asked to sign an updated behavioral intervention form that outlines goals, current circumstances, solutions, plans, and responses as discussed at the wrap-around meeting.
12. _____ I understand that staff will consult with DOC staff including, but not limited to probation officers and correctional officers about my behaviors and/or issues effecting my Reentry Case Management Program participation and progress.
13. _____ I agree to sign releases of information as requested by Reentry Case Management Program and/or DOC staff.
14. _____ I understand that I am responsible for keeping confidentiality of my peers that I may encounter at reentry program events, group, gatherings, or support service meetings.
15. _____ I understand that staff are responsible for maintaining confidentiality per state and federal laws, but also I am aware that in certain cases, confidentiality cannot be kept. I also understand that because I am in the Reentry Case Management Program, staff and DOC staff will communicate about my behaviors/issues impacting my participation and progress. Confidentiality does not apply to the following situations:
    - Child abuse or neglect
    - Harm or assault to a vulnerable adult
    - Harm to self (verbal threats or physical acts)
    - Harm to others (verbal threats or physical acts)
    - Court Order
    - Criminal activity (past or present)

I, _____acknowledge that I have read and received a copy of my Reentry Case Management Program Behavioral Contract. Furthermore, I understand and agree to follow the above conditions.

_____ _____

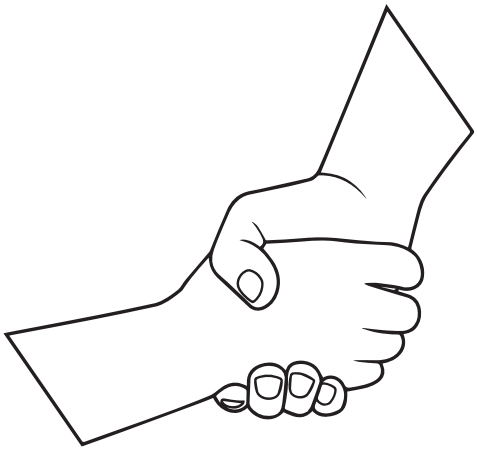
Reentrant signature Date

_____ _____

RSP Reentry Support Group

Starts May 16th 2019

JAMHI
Health & Wellness, Inc.
An NCADD Affiliate



- Learn about resources in the community
- Learn coping skills for daily living
- Learn about relapse prevention skills and strategies
- Learn about motivation and how to get more
- Learn about nutrition and health
- Get help filling out applications

JAMHI Health & Wellness
9AM to 10AM Every Thursday
JAMHI small group room
Open to all JAMHI Reentry Clients
Required for Phase 1 clients

JAMHI
Health & Wellness, Inc.
An NCADD Affiliate

"We help people live their own best lives"

Electronic Communication Consent Form

Risks of using text messaging:

The transmission of information by text messaging has a number of risks that you should consider prior to the use of text messaging. These include, but are not limited to, the following risks:

- Texts can be circulated, forwarded, stored electronically, on paper, and broadcast to unintended recipients.
- Text senders can easily misaddress a text and send information to an unintended recipient.
- Backup copies of texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect texts sent through their company systems (ex. work cell phone).
- Texts can be intercepted, altered, forwarded or used without authorization or detection.
- Texts can be used as evidence in court.
- Texts may not be secure therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of text messaging:

- JAMHI and its providers cannot guarantee, but will use reasonable means to maintain security and confidentiality of text information sent and received.
- JAMHI and its providers cannot guarantee that any particular text will be read or responded to within any particular time. In the event of an emergency, please call 911, or present to the nearest emergency room.

Please acknowledge and consent to the following conditions (please initial):

_____ Texting is not appropriate for urgent or emergency situations.
_____ Texting is not appropriate for communicating complex or sensitive information.
_____ Texts are deleted following each communication (no conversation thread allowed); although some communications may, as applicable, be incorporated into the provider's service note(s).
_____ JAMHI staff will not forward texts with identifying information without written consent, except as authorized by law.
_____ JAMHI and its staff are not liable for breaches in confidentiality caused by the client.
_____ Misuse of the text message service may result in its suspension.
_____ It is your responsibility to follow up, reschedule and/or schedule an appointment if warranted.
_____ It is your responsibility to update your contact information when necessary.

Acknowledgement and Agreement:

I acknowledge that I have read and fully understand the consent form. I understand the risks associated with text messaging and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by text.

_____ _____ _____

Signature Printed Name Date

Guardian Signature (if applicable) _____ _____
Date

Phone Number to be used for text messaging: _____

JAMHI Health & Wellness, Inc.
An NCADD Affiliate

Re-entry Case Management Intake form

Client Profile

1. Name (First and Last) _____
2. Client Gender Female Male
   If female, maiden name required _____
3. Current Address: Street, Apartment _____
   City, State, Zip _____
4. Phone Number(s) _____
5. Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
6. Social Security Number __ __ __ -- __ __ -- __ __ __ __
7. Medicaid ID Number __ __ __ __ __ __ __ __ __ __

Demographics

Race(s): ***Check all that apply***

- ❒ American Indian
- ❒ Asian
- ❒ Black/African American
- ❒ Caucasian
- ❒ Native Hawaiian
- ❒ Pacific Islander
- ❒ Other
- ❒ Unknown
- ❒ Not collected

Alaska Native:

- ❒ Aleut
- ❒ Athabascan (other than Amer. Indian)
- ❒ Haida
- ❒ Inupiat
- ❒ Tlingit
- ❒ Tsimshian
- ❒ Yupik
- ❒ Other Alaska Native

Ethnicity: ***Check one***

- ❒ Not Spanish/Hispanic/Latino
- ❒ Chicano
- ❒ Cuban
- ❒ Hispanic-not otherwise specified
- ❒ Mexican American
- ❒ Puerto Rican
- ❒ Spanish/Hispanic/Latino
- ❒ Unknown
- ❒ Not collected

Special Needs: ***Check all that apply***

- ❒ None
- ❒ Autism
- ❒ Developmentally Disabled
- ❒ Fetal Alcohol Spectrum Disorder
- ❒ Major Difficulty in Ambulating or non-ambulation
- ❒ Moderate to Severe Medical Problems
- ❒ Organically Based Problem
- ❒ Severe Hearing Loss or Deaf
- ❒ Traumatic Brain Injury
- ❒ Visual Impairment or Blind
- ❒ Sex offender
- ❒ Other
- ❒ Unknown
- ❒ No Response

Education completed: ***Check one***

- ❒ No Schooling
- ❒ If K-11, how many years _____
- ❒ General Education Degree (GED)
- ❒ High School Diploma (not GED)
- ❒ Vocational Training beyond High School
- ❒ Special Ed Ungraded Classes
- ❒ Baccalaureate Degree (BA, BS)
- ❒ Graduate work (no degree)
- ❒ Master's degree
- ❒ Doctorate/Professional degree
- ❒ Post Secondary 1 yr
- ❒ Post Secondary 2 yrs
- ❒ Post Secondary 3 yr
- ❒ Post Secondary 4+ yrs (no degree)
- ❒ Other
- ❒ Unknown
- ❒ Not Collected

English Fluency: ***Check one***

- ❒ Excellent
- ❒ Good
- ❒ Moderate
- ❒ Poor
- ❒ Not at all
- ❒ No response

Veteran Status: ***Check one***

- ❒ Never in Military
- ❒ Vietnam Vet; combat
- ❒ Vietnam Vet; no combat
- ❒ Gulf War Vet; combat
- ❒ Iraq War Vet; combat
- ❒ Afghan War Vet; combat
- ❒ Active duty combat
- ❒ Active duty no combat
- ❒ Reserves/Nat. Guard; combat
- ❒ Reserves; no combat
- ❒ Retired from Military; combat
- ❒ Retired Military; non combat
- ❒ Veteran other eras
- ❒ Military Dependent
- ❒ Not Applicable
- ❒ Not Collected
- ❒ Unknown

Intake Information

Clinician/Staff: _____
Date of Completion: _____

Client Last Name, First Initial: _____
Client ID Number: _____

Revised 2/19/2016

JAMHI Health & Wellness, Inc.
An NCADD Affiliate

Re-entry Case Management Intake form

1. File Located At (Where will client be admitted?): _____Juneau_____
2. Intake Staff: _____Michael VanLinden_____
3. Initial Contact: ***Check one***

❒ Phone ❒ Drop In (Orientation) ❒ Hospital/On Call Intervention ❒ Emergency Outreach Intervention	❒ Community Service Patrol ❒ By appointment ❒ Mail or Fax ❒ Other

4. Village (where client currently lives): _____
5. Intake Date: __ __ / __ __ / __ __
6. Source of Referral: _____
7. ***Only required if FEMALE***: Pregnant:___ yes ___no ___unknown If yes, due date: __ __/ __ __/ __ __
8. Injection Drug User (within the past 6 months): ___ yes ___no ___unknown
9. Primary Presenting Problem: _____ (specify from list below)

   Secondary: _____ (specify from list below)

   Tertiary: _____ (specify from list below)

   (Alcohol & Drugs; Alcohol Only; Drugs Only; Suicide attempt/threat; Child abuse victim; Sexual abuse victim; Domestic violence victim; Runaway behavior; Eating disorder; Thought disorder; Depression; Social/interpersonal (not family); Coping with daily roles/activities; Marital; Family (non marital); Legal; Medical/somatic; Psychological/ emotional; Financial; Poverty; Child abuse perpetrator; Sexual abuse perpetrator; Domestic Violence perpetrator; None; Other; Unknown; No response)
10. Presenting Problem(s) in client's own words (Why is the client seeking services?): _____

_____

_____

11. Special Initiative: ***Check all that apply***

❒ None ❒ Anchorage Coordinated Resource Project ❒ Anchorage Family Dependency Court ❒ Anchorage Municipal Wellness Court ❒ Anchorage Veteran's Court ❒ APIC (Assess, Plan, Identify, & Coordinate) ❒ Bethel Therapeutic Court ❒ BTKH – Parenting with Love and Limits ❒ BTKH – Transition to Independence Process ❒ CASII – Matrix ❒ CASII – PLL ❒ CASII – TIP ❒ Disasters ❒ DVSA – Victim Services	❒ Anchorage Felony Drug Court ❒ Anchorage DUI Court ❒ Fairbanks Juvenile Treatment Court ❒ Fairbanks Wellness Court ❒ Juneau Coordinated Resource Project ❒ Juneau DUI Court ❒ Ketchikan Therapeutic Court ❒ Methadone ❒ Palmer Coordinated Resource Project ❒ Psychiatric Emergency Services ❒ Traumatic Brain Injury ❒ Therapeutic Courts ❒ Women w/Children

Did you fill out the Medicaid application while incarcerated? _____

Clinician/Staff: _____ Client Last Name, First Initial: _____
Date of Completion:_____ Client ID Number: _____

Revised 2/19/2016

Reentry Case Management Participant Transition Phase 1 Survey

Survey Type	Transition Phase 1	Transition Phase 2	Transition Phase 3	Aftercare / Discharge
	☐	☐	☐	☐

Participant **ACOMS / OBSIS #**	
Participant **Last Name**	
Participant **First Name**	
Date Survey Completed	Click here to enter a date.

Case Manager Administering Survey	Case Manager Location / Area

Section 1: Transition Phase 1

This section should be filled out by new participants, or participants starting a new case management program.

Why do you want case management services? (Please check all that apply.)

☐ I need housing.
☐ I need treatment.
☐ I need access to healthcare.
☐ I am looking for a job.
☐ I need help connecting to services in the community.

☐ Other: _____

☐ Other: _____

How did you first hear about case management services?

☐ My probation officer told me. / DOC staff told me.

I heard about it from:

☐ Other people in prison/jail.
☐ A reentry case manager.
☐ Family, friends, and/or other organizations.

Additional Comments:

Section 2: Current Status Review

Who completed the survey?

☐ I filled this out by myself.
☐ Someone helped me fill this out.

Participant ACOMS / OBSIS #	Participant Name (Last, First)

Section 2: Current Status Review

What best describes your current housing / living arrangement?

☐ CRC / Halfway House
☐ Homeless or homeless shelter
☐ Transitional / Temporary Housing
☐ Living with family / friends
☐ Rent / Own permanent housing
☐ Jail or correctional facility

☐ Other:_____

What best describes your treatment status?

☐ I do not have treatment / recovery issues. I do not need treatment assistance.
☐ Currently active in treatment / recovery
☐ Not active in treatment / recovery (awaiting appointment)
☐ Not active in treatment / recovery (by choice)

Section 3: How do you feel about the different areas in your life?

How do you feel about:		Dissatisfied	Unhappy		Mixed		Satisfied	Pleased
Your housing?								
Your ability to support your basic needs? *(for example: food, housing, etc.)*								
Your safety in your home or where you sleep?								
Your safety outside your home?								
How much people in your life support you?								
Your friendship?								
Your family situation?								
Your sense of spirituality, relationship with a higher power, or meaningfulness of life?								
Your life in general?								

Additional Comments:

JAMHI Health & Wellness, Inc.
An NCADD Affiliate

JAMHI Health & Wellness, Inc.

Salmon Creek Clinic
3406 Glacier Hwy
Juneau Alaska 99801
907-463-3303

Midtown Clinic
1944 Allen Court
Juneau, AK 99801
907-463-6882

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION

I, _____ , Date of Birth: _____
Name of Client

hereby authorize **JAMHI Health & Wellness, Inc. (JAMHI)** to exchange information/document(s) with/

between the following agency or person: **City and Borough of Juneau, Capital Transit**

ADDRESS: **10099 Bentwood Pl, Juneau, AK 99801**

PHONE # **(907) 789-6901** FAX #: **(907) 586-0912**

INFORMATION TO BE RELEASED/RECEIVED: (Please check)

- ____ Behavioral Health / Substance Use Assessments
- ____ Psychiatric Assessments / Evaluations
- ____ Behavioral Health Treatment Plans
- ____ Medication List / Medication Management Notes
- ____ Functional Assessments
- ____ Redisclosure of third-party records on file at JAMHI for the purpose of payment, treatment and operations
- ____ Medical Records
- ____ Laboratory/Radiology
- ____ APA/Med 11/AD #2 Forms
- ____ Billing Records
- ____ Discharge Summary
- ____ Housing
- ____ Verification of Participation and/or Attendance
- X Other: **Application for a CBJ Bus Pass and/or Care-A-Van Pass**

PURPOSE OF INFORMATION: (Please check)

- ____ Legal Use
- ____ Intake Information
- ____ Employment / Vocational Assistance
- ____ Coordination of Treatment
- X Benefits / Eligibility
- ____ Housing / Tenancy / Eligibility
- ____ Personal / Self
- ____ Other _____

By signing this form I understand that:

* I am authorizing the use and disclosure of my healthcare and/or other information described above; my authorization is voluntary.
* I may revoke this authorization at any time by notifying the individuals(s) or organization releasing this information in writing or verbally, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received.
* The individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable), or eligibility for benefits on whether I provide this authorization.
* The Protected Health Information (PHI) released may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment for substance use disorders. _____ **I do not want this information to be disclosed.**
* I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
* Requests for copies of medical records over ten (10) pages may be subject to copying fees.

DATE / EVENT:

This authorization expires on the following event: _____ or one (1) year from the date of signature if no other date or event is indicated.

_____
Signature of Client Date

_____
Signature of Authorized Representative (if required) Date
AND Description of Representative's Authority

_____
Signature of Witness (not required) Date

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (42 CFR, Part 2) prohibiting you from making any further disclosure of this information, without the specific written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Capital Transit
V.I.P. BUS PASS

Application

Name _____

Address, mailing _____

residence _____

Telephone Home _____ Work _____

Date of Birth _____ Height _____ Weight _____

If you are eligible on the basis of items 1, 2, or 3 listed under Who is Eligible, please attach evidence and sign below. If you are eligible on the basis of item 4, the Medical Eligibility Criteria, please have your physician complete the bottom half of this page. If you are applying for certification of ADA paratransit eligibility, please have your physician complete the back of this form also.
I hereby authorize the physician below to release any information necessary to complete this certification. I understand that if any of the statements made on this certification are false, I will lose the privileges granted by the V.I.P. bus pass. I understand the pass remains the property of Capital Transit and must be surrendered to a Capital Transit employee upon demand.

Applicant's Signature _____ Date _____

Physician's Certification for Persons with Disabilities

I certify that _____ meets
applicant's name

the medical eligibilty criteria, Section _____ . _____ , and is disabled
section number

temporarily _____ , or permanently _____ *(please check one).*

To the physician: The applicant must meet a specific criteria listed under the medical eligibility criteria.

Physician's signature _____ Date _____

Physician's name _____

Telephone _____ Address _____

_____

To determine eligibility for the Care-A-Van service, please continue on the back of this form.