

Personal Data Card, Certification and Authorization for Release of Protected Health Information

Please read, sign, date and mail or drop off at OUTREACH, Inc., 926 Rock Avenue, Suite 10, San Jose, CA 95131 (or) FAX to (408) 382-0470. This form may be downloaded at <http://www.outreach1.org> or <http://www.vta.org> Applications- for individuals who are under the age of 18 years, must be completed by the applicant's parent, legal guardian or custodian. If an applicant is 18 years or older, but is unable to complete the application because of a physical or vision impairment, the applicant must have given permission to the person completing the application. Applications for individuals 18 years of age or older with cognitive impairments, must be completed by the applicant's legal guardian or custodian.

Applications that do not meet the above criteria will not be processed. Thank you in advance for your cooperation. OUTREACH will contact you for a phone interview.

Section 1: Personal Data

Check one:

New Applicant _____

Existing Customer _____

Outreach ID # _____

Applicant Name: _____

(Mr/Mrs/Ms - circle one)

Birthdate: _____

Application Information:

Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone Number: _____

Cell Phone Number: _____

Best time(s) to call: _____

Email: _____

Primary Language: _____

What is your primary disability and/or most limiting condition?

Do you use any mobility aids or specialized equipment?

Yes _____

No _____

If you answered "Yes" please check all that apply:

Cane

White Cane

Walker

Manual Wheelchair

Power Wheelchair

Power Scooter

Leg Braces

Prosthesis

Service Animal

Speech Devices

Crutches

Respirator

Communication Board

Portable Oxygen Tank

Other

Do you need any future written information provided to you in an accessible format?

Yes _____

No _____

If "Yes", please check the format you prefer:

Email _____

Diskette

Audio Tape

Braille

Large Print

Would you be interested in learning more about mobility options and travel training?

Yes

No

Emergency Contact Name: _____

Relationship to Applicant: _____

Phone Number (s): _____

Address: _____

City: _____

State: _____

Zip Code: _____

Section 2: Authorization for Release of Protected Health Information

I understand the protected health information provided during the application and interview process will be kept confidential and shared only with the following professionals or providers as necessary to determine eligibility and provide paratransit services, and for quality assurance/audits to comply with ADA regulations and VTA policy: VTA, OUTREACH and their eligibility representatives, and their contractors.

Section 3: Authorization to Release Medical Information

(Please include the contact information for your physician or licensed professional, who can verify your disability/ies, or has knowledge about your disability/ies and functional limitations.)

I hereby authorize: _____

Name: _____

Address: _____

Phone: _____

FAX: _____

(OPTIONAL) Medical Record/Kaiser Number:

to release the information requested below about my disability or disabilities to OUTREACH eligibility representatives/ contractors upon request. The information released will be used solely to

evaluate my eligibility for VTA paratransit services as required by the Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq. ,104 Stats. 327.

I understand that I have a right to revoke any Section of this authorization at any time by writing to OUTREACH, except to the extent that action has already been taken based upon this authorization.

Applicant Signature: _____

Date: _____

Section 4: Applicant Certification (Please sign)

All applicants must sign the completed application. If this application has been completed by someone other than the person requesting certification, the person who completed the application must provide the following information:

Name of Person Assisting Applicant: _____

Relationship to Applicant: _____

Address _____

City _____

State _____

Zip Code _____

Phone Number: _____

Alternate Number: _____

Signature: _____

Date: _____

By signing this application, you are certifying under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Applicant/Legal Guardian/Conservator Signature:

Date: _____