TRANSIT plus
MILWAUKEE COUNTY PARATRANSIT SERVICES

1942 North 17th Street • Milwaukee, WI 53205-1697
Phone (414) 343-1700 • TTD (414) 343-1704 • FAX (414) 343-1787

TRANSIT PLUS MEDICAL DOCUMENTATION FORM
TO BE COMPLETED ONLY BY A TREATING PHYSICIAN

Transit Plus, Milwaukee County's Paratransit service, is offered in accordance with the Americans with Disabilities Act (ADA) of 1990. Transit Plus is an extension of the Milwaukee County Transit System (MCTS) fixed route bus system. Persons with physical, cognitive, or sensory disabilities may be Transit Plus eligible for the times they are functionally prevented from utilizing the MCTS fixed route (city bus). Transit Plus also provides discounted rates on the MCTS fixed route (city bus) for the times individuals experience difficulty and/or are fully able to utilize the city bus.

Transit Plus is in no way determined by, related to, or comparable to Medicare/Medicaid/T-19/etc, it is not specific specialized medical transport. Disability, age, Social Security status or disability status alone does not determine one's eligibility for Transit Plus. The decision is based solely on the applicant's functional abilities, using specific ADA criteria.

THIS ENTIRE FORM, FRONT AND BACK, IS TO BE COMPLETED AND SIGNED ONLY BY A *TREATING PHYSICIAN.*

Date: _____

***TREATING PHYSICIAN'S ADDRESS:**

_____

_____

_____

_____

***TELEPHONE#:**

_____

***FAX#:**

_____

APPLICANT'S NAME: _____

APPLICANT'S DIAGNOSIS AND DATE DIAGNOSED / ONSET OF ILLNESS:

_____

_____

_____

SIGNATURE of TREATING PHYSICIAN:

NAME & TITLE _____ **DATE** _____

Wisconsin Medical license number (or U-PIN): _____

*******The treating Physician must also complete reverse side of this form.*******

TP49

(OVER)

***THE FOLLOWING SHOULD BE COMPLETED AND SIGNED *ONLY* BY THE TREATING PHYSICIAN LISTED ON THE FRONT OF THIS FORM:**

1. Are you currently treating the applicant? ☐ YES ☐ NO

2. If yes, how long have you been treating the applicant? _____

3. When was the last time you saw the applicant and why? _____

   _____

4. If more then one diagnosis is listed on the front of this form: Which diagnosis most significantly impairs their ability to utilize the city bus/Milwaukee County Transit System?

   _____

5. What is the current severity of the above diagnosis/medical condition?

   ☐ Mild ☐ Moderate ☐ Severe

6. How is the applicant being treated for the above diagnosis? (IE: medication, therapy, programs, etc.)

   _____

   _____

7. How effective are medications and/or therapies in controlling symptoms?

   _____

   _____

8. Would you consider the applicant's condition under control and/or stable? ☐ YES ☐ NO

   If no, please explain:

   _____

   _____

9. Has the applicant been hospitalized in the last 3 months? If so why? _____

   _____

***SIGNATURE of TREATING PHYSICIAN:**

***NAME & TITLE** _____ **DATE** _____

Please Note: Application process may be delayed if form is not SIGNED ON BOTH SIDES and completed in full.