DALLAS AREA RAPID TRANSIT
PARATRANSIT SERVICES
VERIFICATION OF BEHAVIORAL HEALTH OR INTELLECTUAL DISABILITY

Date_____

Applicant's Name_____

DOB_____

It has been determined that due to his/her disability the person named above is eligible for services provide through the Texas Department of Aging and Disability Services.

Please check off or list disability type:

Behavioral Health
☐ Schizophrenia
☐ Bi-polar
☐ Depression
☐ Other_____
_____
_____

☐ Intellectual Disability
☐ Other_____
Pervasive Developmental Disorder (i.e. Autistic)
Please list specific type: _____

Related Conditions (i.e. Traumatic Brain Injury)
Please list specific type: _____

The determination was made or confirmed by this Mental Retardation Authority or this clinician/therapist on _____ (date).

Name of MRA_____

Name of Individual Service Coordinator_____

Telephone number_____

A disability type must be listed or check from above for this section:

Or

Name of Clinician/Therapist_____

Credentials/Qualifications_____

License Number_____ Telephone_____ State_____

I hereby verify that the disability referenced above is accurate to the best of my ability to confirm. _____*Incomplete form will be returned*