

FLASH Card Certification of Medical Eligibility

Complete this form with your healthcare provider. Upload completed document to your online FLASH Card application at: <https://www.seattle.gov/agefriendly/programs/discounts>

I have a medical disability as certified by a Physician, Psychiatrist, Psychologist (PhD), Physician's Assistant (PA), Advanced Registered Nurse Practitioner (ARNP) or Audiologist, licensed in Washington.

Applicant's Release: I hereby authorize the physician to release any information necessary to complete this certification. I understand that this information is confidential and shall not be released without my approval or a court order. I understand that Age Friendly Seattle shall have the right and opportunity to verify my eligibility for a FLASH Card. I understand that if any of the statements made on this application form are false or inaccurate, I will lose the privileges granted by the FLASH Card and may be subject to criminal prosecution in accordance with Washington State Law for theft (RCW 9A.56.020).

* Applicant's Signature: _____ * Date (mm/dd/yyyy): _____

Section below to be completed by an approved Health Care Provider.

These Washington State-Licensed Health Care Providers are acceptable: Physician (MD or ND), Audiologist certified by the American Speech, Language and Hearing Association, Psychiatrist (MD), Physician's Assistant (PA), Psychologist (PhD), Advanced Registered Nurse Practitioner (ARNP).

Instructions:

- This applicant must meet at least one of the criteria and conditions listed in [King County Metro Transit's Medical Eligibility Criteria and Conditions brochure](#) (page two).
- The specific Medical Eligibility Criteria number must be noted in the space provided, below.
- If Section 6.4 is used, this person must be diagnosed by you as being "Acute-at-risk." The appropriate subsection (a, b, c, or d) must be included along with the name and phone number of the work activity center, training or rehabilitation program in which this patient is currently a patient. Note: An applicant's enrollment in a drug or alcohol rehabilitation program does not, in and of itself, meet eligibility requirement.
- An applicant's financial situation has no bearing on eligibility.

* Approved Health Care Provider only:

To complete, refer to Medical Eligibility Criteria & Conditions brochure, above.

* I certify that _____ meets the Medical Eligibility Criteria _____
(Applicant) (SECTION & SUBSECTION Number)

* If Section 6.4, (a, b, c, or d), enter name of qualifying program: _____

* Please check the appropriate boxes:

- ☐ Yes ☐ No The disability is Temporary. Specify length of disability: _____ months. A temporary disability must be expected to last at least three months, but no longer than one year.
- ☐ Yes ☐ No The disability is Permanent.
- ☐ Yes ☐ No This applicant requires a Personal Care Attendant (if yes: ☐ temporary / ☐ permanent)

* Verification of Approved Health Care Provider (Please Print)

* Name: _____ * Phone (incl. area code): _____

* Provider or Agency Name & Address: _____ * Phone: _____

* Washington State License No: _____

I understand that if any of the statements made on this application form are false or inaccurate, I will be subject to criminal prosecution in accordance with Washington State Law for theft (RCW 9A.56.020).

* Signature: _____ * Date (mm/dd/yyyy): _____