



Community-Based Transition Program (CBTP)

Central Administration Building Annex
601 S. 8th Street, First Floor Rm. B
Tacoma, WA 98405

The Program

CBTP is a Diversified Occupations program for students 18-21 years of age who have been identified as having one or a variety of disabilities. The program combines the expertise of Special Education and Career & Technical Education staff to provide participants job and life skills training, and whenever possible, job placement.

The Mission

Prepare students for full integration into the community; with the emphasis on employment, independence, and community access.

The Vision

Quality learning occurs in an environment that supports & encourages integrity, personal choice and self-reliance.

Student achievement results from continuous development of successful workplace skills & appropriate workplace attitudes.

Frequently Asked Questions

What is the focus of CBTP?

The program focuses on providing trainees a variety of community-based work, functional academic, and life experiences to help them achieve their goal.

What are the steps for admission into program?

Step 1: Family and home high school staff complete referral packet, and submit them to CBTP staff

Step 2: Family and CBTP staff schedules a family interview.

Step 3: CBTP staff schedules a trainee interview with the business partner at their site where training is held

Step 4: Student w/a family member completes *Reading Free Interest Inventory* or *The Career Decision Making* with staff support.

Step 5: Family/student/staff sign *Training Agreement*

What do the students, families/ guardian gain through the CBTP?

The program is one means by which students achieve an independent and productive future through:

- acquisition of varied job skills & appropriate work behavior
- timely link up with service agencies
- .5 credit per semester upon completion of requirements
- job search with staff help when ready
- when possible & after passing required community colleges' entrance tests, enter college through Running Start

How long is the training program?

Training hours last for 6 hrs. per day, Monday through Friday. Trainees can participate in the program for up to 3 years with services terminating at the end of the school year the student becomes 21 years old.

Must a trainee remain at one training site?

A trainee may seek or may be asked to extend training time at the same site. They may also request for transfer or be transferred to other sites. The program encourages trainees to move to other sites to learn more skills or experience another work environment. The process of choosing sites considers trainees' & sites' needs thus it involves student, parents and business partners' input.

When do trainees look for paid employment?

When job readiness has been demonstrated for some time, trainee's job search begins with the help of CBTP job developer. Trainee goes to interview with probable employers who make the final decisions in hiring. **CBTP cannot guarantee employment.** Employer may request CBTP staff to job coach the newly hired for a couple of weeks.

5 Major Areas of Instruction

- Job Skills Development
- Job Search & Job Retention
- Functional Academic Skills
- Leadership, Self-Development, Self Advocacy
- Life & social Skills

PLEASE NOTE: Trainees need to be aware that they also gain job experience at home. House chores equate to jobs. Example: dishwashing, planning work & leisure, doing laundry, etc.

Current CBTP Training Sites:

Metro Parks Greenhouse (Non-District Sites)

5402 N. Shirley, Tacoma, WA 98407
(253)-591-5292

Skills:

- Plant Care • Custodial
- Environmental & Plant Materials Maintenance • Functional math, reading & writing • Community Access

St. Vincent de Paul Thrift Stores (Non-District)

4009 S. 56th St. Tacoma WA 98409
(253)-474-0519

Skills:

- Used Products Processing
- Zoning • Custodial
- Customer Service • Functional math, reading & writing • Community Access

MultiCare Tacoma General (Non-District)

315 Martin Luther King Way
Tacoma, WA 98405
(253) 403-5054

Skills:

- Office assistance; Print Shop assistance
- Laundry Room/Housekeeping assistance
- Paper Shredding & Recycling
- Communications & data entry assistance
- Community Access

Revised: 10/2007

Park Avenue (Tacoma School District)

6701 S. Park Avenue, Tacoma, WA 98408
(253) 571-3478

Skills:

- Recycling & Shredding
- Sorting Recyclable Print Materials
- Functional math, reading & writing
- Community Access

Head Start/Tone (Tacoma School District)

3102 S. 43rd St., Tacoma, WA 98409
(253) 571-3600

Skills:

- Assisting teaching staff • Food handling
- Organizing materials/activities • Sorting/stocking donated materials for distribution
- Reading request forms & filling in requests
- Functional math, reading & writing
- Community Access

Science Materials Resource Center, PDC (Tacoma School District)

6501 N. 23rd, Tacoma, WA 98406
(253) 571-3512

Skills:

- Sorting & packaging science materials
- Shelf assembly • Stocking materials
- Filling in requests • Functional math, reading & writing • Community Access

Four Ps: Unique students job training and leadership needs can be met through:

IEP Pathways Projects Portfolio

Some expected observable & positive outcomes of 4Ps:

- Student attendance improves because training is relevant with actual workplace expectations
- Parents get more involved since their input and actions are integral part of trainee's 4Ps
- Trainee achieves expressed goals.

Essential Academic Learning Requirements

CBTP aligns its curriculum with the EALRs through measurable & applied competencies.

Goal 1: Read, write & communicate in a variety of ways & settings

Goal 2: Apply core concepts/principles of math; social, physical & life sciences; civics, history, geography, arts, & health fitness

Goal 3: Think analytically, logically & creatively; integrate experience & knowledge to form reasoned judgement in solving problems

Goal 4: Understand the importance of work; how performance, effort and decisions affect career and educational opportunities:

5 Goals of Work-Based Learning:

- Enhance motivation & functional academic achievement
- Increase personal & social competence related to work in general
- Gain a broad understanding of an occupation or industry
- Experience career exploration & planning
- Gain skills related to particular occupations as well as related work competencies

For more information, please contact any of the following:

*John Goebel, Special Education Asst. Director (253) 571-1145
Glenn Burden, Work-Based Learning Coordinator (253) 571-1091
Career/Technical Education & Special Education
Carolyn Devereaux, Special Ed. Site Coordinator (253) 571-1026
Edie Pelham, Special Ed. Site Coordinator (253) 571-1009
Cathy Sanderson, Special Ed. Transition Specialist (253) 571-1394*



Tacoma Public Schools

Community-Based Transition

Student Name _____ Referring Staff _____

REFERRAL PACKET & CHECKLIST (Staff Member)

Dear Staff Member:

Attached to this checklist is your **Referral Packet** for Community-Based Transition.

- _____ **Referral Form** (pages 1 & 2)
This needs to be filled out thoroughly by you.
- _____ **NDDPI/GST Skills Master Checklist or Adolescent Autonomy Checklist**
Appendix 2 or Appendix 9 --- Located in the Tacoma School District Transition Guide
- _____ **Sexuality Assessment**
Appendix 16 --- Located in the Tacoma School District Transition Guide
- _____ **Getting to Know Your Anger**
Appendix 13 --- Located in the Tacoma School District Transition Guide
- _____ **Career Portfolio**
 - Career Cruising information or Reading Free Inventory
 - Current resume
 - Letters of recommendation
 - List of references
 - Job evaluations
 - LCCE assessment results or modified version of LCCE

Please supply copies of the following forms:

- _____ **Current Psychological Evaluation Report**
- _____ **Current IEP**
- _____ **Current FBA/PBIP (if applicable)**
- _____ **Attendance History from eSIS**
- _____ **Current DDD Comprehensive Care Plan (if applicable)**

*If you have any questions, regarding this referral packet, please contact **Cathy Sanderson** at (253) 571-1394.*

Please send the fully completed staff and parent referral packets to:

Community-Based Transition – CAB/Annex

Thank you for this valuable information and your cooperation in helping your student move from the high school setting into the Community-Based Transition setting.

The Community-Based Transition Staff



Community-Based Transition Program

REFERRAL PACKET LETTER: PARENT/GUARDIAN ONLY

Dear Parent/Guardian:

Attached is the parent/student portion of the Referral Packet for the Community-Based Transition Program. Please fill out the following forms and please complete **ALL PARTS OF ALL FORMS IN BLACK INK,**

 Parent/Guardian Questionnaire

Please fill out this form thoroughly. This page provides the staff with information about your dreams and goals for your son/daughter, and their goals, which will assist us in providing opportunities for these goals to be accomplished.

 Current Health Information/Medical/Medication Forms

Please fill it out as thoroughly as possible, including the appropriate physician names and telephone numbers.

 Reduced Fare Permit (Pierce Transit Bus Pass)

Please complete a Pierce Transit Reduced Fare permit for your son/daughter prior to entering into Community-Based Transition Program. This is the parent/student's responsibility. **This is an easy process - fill out the enclosed packet, take proof that he/she is disabled (Listed in the application packet), take your son/daughter to the Bus Shop at 904 Broadway or to the Pierce Transit headquarters at 96th and South Tacoma Way. Paying \$3.00, your son/daughter will get a picture ID.** The Community-Based Transition Program will supply the monthly bus pass while your son/daughter is a participant in the Program.

 Washington State Identification

It is very helpful for your son/daughter to have picture Identification with them at all times. The best kind is from the Washington State Licensing Department. It costs you \$20.00. You also need to take a certified copy of at least two of the following documents: your son/daughter's birth certificate, social security card, or medical coupon.

*******Please supply CBTP copies of the following documents, only if your son/daughter has obtained these documents. These documents are not a requirement to enroll in CBTP.**

 Birth Certificate Selective Service (males only) Reduced Bus Fare Permit

 Washington State Identification Voter Registration

If you have any questions regarding this referral, please contact **Cathy Sanderson (253) 571-1394.**

*******Please send the completed parent referral to your son/daughter's high school contact person, so that they can send your portion along with the staff referral packet.**

Thank you for this valuable information and your cooperation in helping your student move from the high school program into the Community-Based Transition Program.

Community-Based Transition Staff

Community Based Transition Program

Date _____

Telephone _____

Referred by _____

TRAINEE

Name _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Birthdate _____ Student # _____

Social Security # _____

Disability _____

Wash. St. ID #/Driver's Lic. # _____

PARENT

Parent/Guardian _____ Telephone (home) _____ (work) _____

Address _____ City _____ State _____ Zip _____

HEALTH

Adaptive Needs _____

Endurance _____

Medications _____

Hearing/Speech _____

Medical Issue(s) _____

Vision _____

EDUCATION

Education:

High School _____ Telephone _____

Address _____ Date of Graduation _____

City _____ State _____ Zip _____ Contact Person _____

Learning Style (how student learns/relearns best): _____

Work Environment (clean/dirty, noisy/quiet, inside/outside, individual/group, brightly/dimly lit): _____

Hobbies & Interests: _____

Transportation: Independently rides public transit? Yes No Bus # _____

Date _____

Community Based Transition Program

WORK/TRAINING

Vocational Training:

<i>Program Name</i>	<i>Type of Training</i>	<i>Duration</i>
_____	_____	_____
_____	_____	_____

Work Experience (volunteer or paid)

Employer _____ Supervisor _____

Address _____ Telephone _____

City _____ State _____ Zip _____ Dates of employment _____

Duties _____ Paid Unpaid

Employer _____ Supervisor _____

Address _____ Telephone _____

City _____ State _____ Zip _____ Dates of employment _____

Duties _____ Paid Unpaid

Employer _____ Supervisor _____

Address _____ Telephone _____

City _____ State _____ Zip _____ Dates of employment _____

Duties _____ Paid Unpaid

Employer _____ Supervisor _____

Address _____ Telephone _____

City _____ State _____ Zip _____ Dates of employment _____

Duties _____ Paid Unpaid

Employer _____ Supervisor _____

Address _____ Telephone _____

City _____ State _____ Zip _____ Dates of employment _____

Duties _____ Paid Unpaid

Date _____

Community Based Transition Program

Student/Trainee Name _____

Birthdate _____

CONTACTS

Emergency Contacts:

Name _____ Telephone _____

Doctor _____ Telephone _____

Agency Contacts:

DDD Case Manager _____ Telephone _____

Community Counselor _____ Telephone _____

DVR Counselor _____ Telephone _____

LEARNING

Learning Style: (how does the student/trainee learn/relearn best?) _____

Work Environment: (*circle all that apply*—clean/dirty, noisy/quiet, inside/outside, individual/group, bright/dimly lit) _____

Hobbies & Interests: _____

Are there any behavioral issues (safety, hygiene, money management, inappropriateness) that need to be addressed? If so, what are they? _____

How do you deal with these behaviors at home? _____

List jobs at home: _____

REFERENCES

References: (for a resume')

Name _____

Telephone _____

Business/Company _____

Address _____

City _____ State _____ Zip _____

References: (for a resume')

Name _____

Telephone _____

Business/Company _____

Address _____

City _____ State _____ Zip _____

List questions you would like addressed through the Community Based Transition Program experiences (e.g., employment, independent living, recreation, etc.): _____

Parent/Guardian Signature _____

Date _____

Reviewed by: _____ Staff Signature	Date: _____
Is there an accompanying signed Certificate of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	



DOH 348-013
Rev: 10/15/08

Certificate of Immunization Status (CIS)

Child's Last Name:	First Name:	Middle Initial:	Child's Address:
Child's Birthdate:			Child's Sex:
Parent/Guardian Name:			Parent/Guardian Day Phone:

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age	Vaccine	Dose	Date	Age		
◆ Hepatitis B (Hep B)				● Pneumococcal (PCV, PPV)				Hepatitis A (Hep A)					
	1				1				1				
	2				2				2				
	3				3								
	4				4								
Hepatitis B (Hep B) Alternate schedule for teens				◆ Polio (IPV, OPV)				Meningococcal (MCV4, MPSV4)					
	1				1				1				
	2				2								
Rotavirus				Influenza (most recent)				Human Papillomavirus (HPV)					
	1				1				1				
	2				2				2				
	3				3				3				
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				◆ Measles, Mumps, Rubella (MMR)				Other					
	1				1								
	2				2								
	3												
	4												
	5												
◆ Diphtheria, Tetanus, Pertussis (Tdap, Td)				◆ Varicella (chickenpox)				<p>I certify that the information provided here is correct and verifiable.</p> <p>_____ Signature of Parent or Guardian</p> <p>_____ Date</p>					
	1				1								
	2				2								
	3												
	4												
● Haemophilus influenzae type b (Hib)				<p>▼ Verification of varicella disease history ▼</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Health Care Provider (HCP) Verified ▶</td> <td style="width: 50%;"><input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶</td> </tr> <tr> <td><input type="checkbox"/> HCP Verified by Registry ▶</td> <td><input type="checkbox"/> No HCP Sig required if box at left checked.</td> </tr> <tr> <td><input type="checkbox"/> Parental Report ▶</td> <td>ONLY acceptable for some grades. Write date or age child had disease:</td> </tr> </table>				<input type="checkbox"/> Health Care Provider (HCP) Verified ▶	<input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶	<input type="checkbox"/> HCP Verified by Registry ▶	<input type="checkbox"/> No HCP Sig required if box at left checked.	<input type="checkbox"/> Parental Report ▶	ONLY acceptable for some grades. Write date or age child had disease:
<input type="checkbox"/> Health Care Provider (HCP) Verified ▶	<input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶												
<input type="checkbox"/> HCP Verified by Registry ▶	<input type="checkbox"/> No HCP Sig required if box at left checked.												
<input type="checkbox"/> Parental Report ▶	ONLY acceptable for some grades. Write date or age child had disease:												
<p>See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.</p>				<p>Licensed HCP Signature (MD, DO, ND, PA, ARNP) _____ Date _____</p> <p>Either initial with parent approval or get parent signature below:</p> <p>Staff initials indicating parent approval: _____</p> <p>Parent Signature indicating approval: _____</p>									

Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

- Diphtheria
 Hepatitis A
 Hepatitis B
 Hib
 Measles
 Mumps
 Polio
 Rubella
 Tetanus
 Varicella
 Other (list): _____ lab report(s) attached (required)

X
 Typed or Printed Name of **Licensed Health Care Provider** (MD, DO, ND, PA, ARNP)

X
 Signature of **Licensed Health Care Provider** (required) Date (required)

Vaccine Trade Names*

Read down and across - Trade Names are in Alphabetical Order.

Trade Name	Vaccine	Trade Name	Vaccine
Acel-Imune	DTaP	Menomune	MPSV4
ActHIB	Hib	OmniHIB	Hib
Adacel	Tdap	Pediarix	DTaP + IPV + Hep B
Boostrix	Tdap	PedvaxHIB	Hib
Certiva	HPV	Pentacel	DTaP + IPV + Hib
Comvax	Hib + Hep B	Pentavalente	DTaP + Hep B + Hib
Daptacel	DTaP	Pneumovax	PPV23
Decavac	Td	Prevnar	PCV or PCV7
Engerix-B	Hep B	ProHIBit	Hib
Fluarix	Flu	ProQuad	MMRV
FluMist	Flu	Quadracel	DTaP + IPV
Fluvirin	Flu	Recombivax	Hep B
Fluzone	Flu	Rotarix	Rotavirus
Gardasil	HPV	RotaTeq	Rotavirus
Havrix	Hep A	Tetramune	DTP + Hib
HibTITER	Hib	TriHIBit	DTaP + Hib
HyperTET	TIG	Tri-Immunol	DTP
HyperHEP B	HBIG	Tripedia	DTaP
Ipol	IPV	Twinrix	Hep B + Hep A
Infanrix	DTaP	Vaqa	Hep A
Kinrix	DTaP + IPV	Varivax	Varicella
Menactra	MCV4		

Vaccine Abbreviations*

Read down – Abbreviations are in Alphabetical Order.

Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus
DTaP	Diphtheria, Tetanus, acellular Pertussis
DTP	Diphtheria, Tetanus, Pertussis
Flu (TIV or LAIV)	Influenza
HBIG	Hepatitis B Immune Globulin
Hep A (HAV)	Hepatitis A
Hep B (HBV)	Hepatitis B
Hib	<i>Haemophilus influenzae</i> type b
HPV	Human Papillomavirus
IPV	Inactivated Poliovirus Vaccine
MCV4	Meningococcal Conjugate Vaccine
MPSV4	Meningococcal Polysaccharide Vaccine
MMR	Measles, Mumps, Rubella
MMRV	Measles, Mumps, Rubella, Varicella
OPV	Oral Poliovirus vaccine
PCV or PCV7	Pneumococcal Conjugate Vaccine
PPV23	Pneumococcal Polysaccharide Vaccine
Rota (RV1 or RV5)	Rotavirus
Td	Tetanus, Diphtheria
Tdap	Tetanus, Diphtheria, acellular Pertussis
TIG	Tetanus immune globulin
VAR or VZV	Varicella

*These lists may not be comprehensive; visit <http://www.doh.wa.gov/cfh/immunize/forms/default.htm> for updated lists.

Health Services Department Tacoma Public Schools
Health History Update Community Based Program

Student Name _____ Grade _____ Birthdate _____

Parent Name _____ Home Phone _____ Cell/Work _____

Physician _____ Phone _____ Dentist _____ Phone _____

(If you need information about health insurance, please contact your school nurse.)

Are any of the following a health problem? Please explain.

Allergies Yes No Type/Reaction _____

Medication requirements? _____

Anemia, Sickle cell Yes No Explain _____

Arthritis Yes No Type _____

Asthma Yes No Type _____

Medication requirements _____

Specific instructions _____

Attention Deficit Yes No Medication _____

Dental Yes No Last Dental checkup _____

Diabetes Yes No Insulin _____

Hearing Yes No Aides? _____ Infections? _____

Heart/Circulatory Yes No Explain _____

Muscle/Skeletal Yes No Explain _____

(Muscles, bones, sprains, strains, breaks)

Seizure Disorder Yes No Type _____

Medication requirements _____

Other Neurological Disorders

Yes No Explain _____

Thyroid Yes No _____

Vision Yes No Glasses or Contacts _____

Do you take medication? Explain _____

Last physician check up _____

Recent Immunizations obtained: Type/Date _____

Do you have any other concerns that are not listed above that would limit ability to participate fully in physical education or other related activities? Yes No

If yes, Explain _____

NOTE: Any medications required to be given at school or work must have a current, signed, permission AND physician order form on file. This applies to both prescription and over the counter medication. Medicine must be in current labeled bottle.

I understand this information may be shared with school district staff as needed to protect the health and safety of the above trainee and to plan for a safe environment conducive to learning.

Trainee Signature _____

Parent/Guardian Signature _____ Date _____

Your Program Nurse Cathy Barker, RN, BSN, NCSN

(Please use back of this form to provide any additional health information. Thank you.) (12/07)

Pierce County Medical Society Physician's Orders for Medication at School

Patient: _____

Medication is ordered to be given to a student at school only when absolutely necessary. Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours. If this is not possible, it must be understood by the parent that the medication will be dispensed by the principal or his/her designee if the school nurse is not present. The principal will designate the person responsible to dispense medication on an individual basis.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Is it necessary to dispense this medication during school hours? Yes No

If yes, please give diagnosis or reason: _____

Drugs and dosage form: _____

Dose and mode of administration: _____

Time(s) to be given: Lunch Hour _____ PRN

Duration without subsequent order: _____ weeks _____ months _____ school year Other: _____

Side effects of drug (if any) to be expected: _____

Medication to be carried by student: Yes No Not Applicable

Physician Signature: _____ **Print or stamp name:** _____

Date: _____ **Phone:** _____ **Fax:** _____

Parent's Permission

I request that the school nurse, principal or a staff member designated by him/her be permitted to dispense to my child,

(name of child) _____ the medication prescribed by

(name of physician) _____ for a period from _____ to _____.

The medication is to be furnished by me in the original container labeled by the pharmacy or physician with the name of the medicine, the amount to be taken, and the time of day to be taken. The physician's name is on the label.

I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered in accordance with the physician's directions.

This authorization is good for the current school year only.

In case of necessity the school district may discontinue administration of the medication with proper advance notice. If notified by school personnel that medication remains after the course of treatment, **I will collect the medication from the school or understand that it will be destroyed.** I am the parent or the legal guardian of the child named.

Date: _____ **Signature of Parent/Guardian** _____

Parent Contact Numbers: Home: _____ Other: _____ School: _____

REGIONAL REDUCED FARE PERMIT

For Senior and Disabled Persons

Medical Eligibility Criteria and Conditions



Available in Accessible Format
April 2003

Regional Reduced Fare Permit for Senior and Disabled Persons

What is it?

The Regional Reduced Fare Permit simplifies travel for senior and disabled riders of public transportation around Puget Sound. The following public transportation systems in the Puget Sound region recognize this identification card:

- Community Transit
- Everett Transit
- Intercity Transit
- Jefferson Transit
- Kitsap Transit
- Mason Transit
- Metro Transit
- Pierce Transit
- Seattle Waterfront Streetcar
- Skagit Transit
- Sound Transit
- Washington State Ferries

With the Regional Reduced Fare Permit, eligible persons do not need to carry more than one permit to receive reduced-fare benefits of multiple systems within the region.

Who is Eligible?

Any person who presents proof of one or more of the following conditions can obtain a Regional Reduced Fare Permit:

1. Is at least 65 years of age.
2. Is now eligible for Social Security Disability Benefits or now receives Supplemental Security Income Benefits because of disability. (Temporary)
3. Is currently certified at a 40 percent or greater disability level by the Veterans Administration.
4. Has a valid Medicare card issued by the Social Security Administration. (Temporary)
5. Has a valid Regional ADA Paratransit card.
6. Has a valid ADA Paratransit card from outside the region. (Temporary)
7. Has obvious physical impairments meeting one or more of the medical criteria listed on the next page (“Medical Eligibility Criteria”).
8. Is currently enrolled by a Washington State Individual Educational Program (IEP). (Temporary)
9. Is certified by a Washington State-licensed physician (M.D.), psychiatrist, psychologist (Ph.D.), Physician Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.), or audiologist (certified by the American Speech and Hearing Association) as meeting one or more of the medical criteria listed to the right.

Where is it issued?

Any eligible person may apply for Regional Reduced Fare Permit at the customer service offices of any of the participating transit agencies. Washington State Ferries, Seattle’s Waterfront Streetcar, Sound Transit and Mason Transit do not issue the permits but will honor those issued by any of the other systems. Any applicant with a valid Regional ADA Paratransit card must apply to the transit agency where that person lives.

How long is it valid?

Permits issued to persons 65 or older and to persons permanently disabled will be valid indefinitely. No renewal is necessary. Persons with disabilities that will last between three months and one year may receive temporary permits. These permits, which carry an expiration date, may be renewed only if the disability continues beyond that date. Persons certified by approved health care providers as permanently disabled may receive permanent permits. Participating agencies retain the right to ask for recertification upon loss of a permit or at any other time.

What does it cost?

An individual must pay a fee of \$3 to obtain the permit. Replacement permits may be obtained from the issuing agency for \$3 or less.

How does it work?

The permit is an identification card used as proof of eligibility to pay a reduced fare. The permit has no cash value and may not be used as a transfer between systems. The permit holder must pay the amount of the reduced fare on each system used, and use of the permit is subject to any time restrictions in effect by each system.

Questions?

If you have comments or questions regarding the Regional Reduced Fare Permit, please contact your local agency. Participating agencies are listed in this brochure.

This agency reserves the right to contact your Health Care Provider for verification.

Medical Eligibility Criteria

Section 1. Non-Ambulatory Disabilities

1. **Wheelchair-User.** Impairments which, regardless of cause, confine individuals to wheelchairs.

Section 2. Semi-Ambulatory Physical Disabilities

1. **Restricted Mobility.** Impairments which cause individuals to walk with difficulty including, but not limited to, individuals using a long leg brace, a walker or crutches to achieve mobility, or birth defects and other muscular/skeletal disabilities, including dwarfism, causing mobility restriction.
2. **Arthritis.** Persons who suffer from arthritis causing a functional motor defect in any two major limbs. (American Rheumatism Association criteria may be used as a guideline for the determination of arthritic handicap; Therapeutic Grade III, Functional Class III, or Anatomical State III or worse is evidence of arthritic handicap.)
3. **Loss of Extremities.** Persons who suffer anatomical deformity of or amputation of both hands, one hand and one foot, or lower extremity at or above the tarsal region. Loss of major function may be due to degenerative changes associated with vascular or neurological deficiencies, traumatic loss of muscle mass or tendons, bony or fibrous ankylosis at unfavorable angle, or joint subluxation or instability.
4. **Cerebrovascular Accident.** Persons displaying one of the following, four months post-CVA:
 - a. Pseudobulbar palsy or
 - b. Functional motor defect in any of two extremities, or
 - c. Ataxia affecting two extremities substantiated by appropriate cerebellar signs or proprioceptive loss.
5. **Respiratory.** Persons suffering respiratory impairment (dyspnea) of Class 3 or greater as defined by "Guides to the Evaluation of Permanent Impairment: The Respiratory System," Journal of the American Medical Association, 194:919 (1965).
6. **Cardiac.** Persons suffering functional classification III or IV and therapeutic classifications C, D, or E cardiac disease as defined by Diseases of the Heart and Blood Vessels – Nomenclature and Criteria for Diagnosis, New York Heart Assoc. (6th Edition).
7. **Dialysis.** Persons who must use a kidney dialysis machine in order to live.
8. **Disorders of Spine.** Persons disabled by one or more of the following:
 - a. Fracture of vertebra, residuals or, with cord involvement with appropriate motor and sensory loss; or
 - b. Generalized osteoporosis with pain, limitation of back motion, paravertebral muscle spasms, and compression fracture of vertebra; or
 - c. Ankylosis or fixation of cervical or dorsolumbar spine at 30 degrees or more of flexion measured from the neutral position and one of the following:
 - 1) Calcification of the anterior and lateral ligaments as shown by x-ray; or
 - 2) Dilateral ankylosis of sacroiliac joints and abnormal apophyseal articulation as shown by x-ray.
9. **Nerve Root Compression Syndrome.** A person disabled due to any cause by:
 - a. Pain and motion limitation in back of neck; and
 - b. Cervical or lumbar nerve root compression as evidenced by appropriate radicular distribution of sensory, motor and reflex abnormalities.
10. **Motor.** Persons disabled by one or more of the following:
 - a. Faulty coordination or palsy from brain, spinal or peripheral nerve injury; or
 - b. A functional motor deficit in any two limbs; or
 - c. Manifestations significantly reducing mobility, coordination and perceptiveness not accounted for in prior categories.
11. **HIV Disease.** A person disabled by HIV disease who meets Social Security eligibility criteria or who meets Washington State (GAU/Welfare) medical criteria.

Section 3. Visual Disabilities

1. Persons disabled because of:
 - a. Visual acuity of 20/200 or less in the better eye with correcting lenses; or
 - b. Contraction of visual field:
 - 1) So the widest diameter of visual field subtending an angular distance is no greater than 20 degrees; or
 - 2) To 10 degrees or less from the point of fixation; or
 - 3) To 20 percent or less visual field efficiency.
2. Persons who, by reason of a visual impairment, do not qualify for a Driver's License under regulations of the Washington State Department of Motor Vehicles.

Section 4. Hearing Disabilities

1. Persons disabled because of hearing impairments manifested by one or more of the following:
 - a. Better ear pure tone average of 90 dB HL (unaided) for tones at 500, 1000, 2000 Hz; or
 - b. Best speech discrimination score at or below 40% (unaided) as measured with standardized testing materials.
2. Eligibility may be certified by a physician licensed by the State of Washington or by an audiologist certified by the American Speech, Language, Hearing Association.

Section 5. Neurological Disabilities

1. **Epilepsy**
 - a. Persons disabled by reason of:
 - 1) A clinical disorder involving impairment of consciousness, characterized by uncontrolled seizures (grand mal or psychomotor) substantiated by EEG occurring more frequently than once per week in spite of prescribed treatment with:
 - a) Diurnal episodes (loss of consciousness and convulsive seizure); or
 - b) Nocturnal episodes which show residuals interfering with activity during the day; or
 - c) A disorder involving petit mal or mild psychomotor seizures substantiated by EEG occurring more frequently than once per week in spite of prescribed treatment with:
 - i. Alteration of awareness or loss of consciousness; and
 - ii. Transient postictal manifestations of conventional or antisocial behavior.
 - b. Persons exhibiting seizure-free control for a continuous period of more than six (6) months duration are not included in the statement of epilepsy defined in this section.
 2. **Neurological Handicap.** A person disabled by cerebral palsy, multiple sclerosis, muscular dystrophy, or other neurological and physical impairments not controlled by medication.

Section 6. Mental Disabilities

1. **Developmental Disabilities:** Permanent Permit. Persons disabled due to mental retardation, autism or other conditions found to be closely associated with mental retardation or to require treatment similar to that required by mentally retarded individuals and:
 - a. The disability originates before such individual attains age 18,
 - b. The condition has continued, or can be expected to continue, indefinitely,
 - c. The condition substantially limits one or more major life activities on an ongoing basis.
2. **Adult Cognition Impairments:** Permanent Permit. Persons whom by reason of traumatic brain injury, illness or other accident occurring after age 18 experience ongoing impairment(s) in cognition that substantially limit(s) one or more major life activities, including individuals who meet SSA, SSI or SSDI eligibility criteria.
3. **Serious Persistent (Chronic) Mental Illness:** Permanent Permit. Individuals with a mental illness with symptoms chronic in nature who experience a significant limitation in their ability to take part in major life activities AND who meet one of the following:
 - a. Having a mental disorder diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM);
 - b. Living in a group/boarded home setting, receiving state or federal financial assistance and participating in a state or federally funded work activity center or workshop;
 - c. Permanently placed in a supervised or supported living arrangement;
 - d. Addressing mental health needs by participating in any training/rehabilitation program or therapy established under federal, state, county, Regional Support Network (RSN) or city government agencies.
4. **Serious Mental Illness (Acute at-risk):** Temporary Permit. Individuals with a mental illness who are currently experiencing a significant limitation in their ability to take part in major life activities AND who meet one of the following:
 - a. Having a mental disorder diagnosis based on criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM);
 - b. Living in a group/boarded home setting, receiving state or federal financial assistance and participating in a state or federally funded work activity center or workshop;
 - c. Living at home under supervision and participating in a state or federally funded state or federal work activity center or workshop;
 - d. Addressing mental health needs by participating in any training/rehabilitation program or therapy established under federal, state, county, Regional Support Network (RSN) or city government agencies.



Community Transit
Community Transit Ridestore
20110 46th Avenue West • Lynnwood, WA 98036
(425) 348-2350 • Toll Free 1-800-562-1375 • TDD/TTY (425) 778-2188



Everett Transit
3201 Smith Avenue, Suite 136 • Everett, WA 98201
(425) 257-7777 • TDD/TYY (425) 257-7778 • Everett Para Transit (425) 257-8801



Intercity Transit
222 State Avenue N.E. • Olympia, WA 98501
(360) 786-1881 • Toll Free 1-800-287-6348 • TDD/TTY (360) 943-5211
Dial A Lift (360) 754-9393 • Toll Free 1-800-244-6846



Jefferson Transit
1615 W. Sims Way • Port Townsend, WA 98369
(360) 385-4777 • TDD/TTY 1-800-833-6388 • Dial-A-Ride (360) 385-4777



Kitsap Transit
10 Washington Avenue • Bremerton, WA 98337
(360) 373-BUSS • From Seattle: (206) 242-8355 • Toll Free 1-800-501-RIDE
Kitsap Transit ACCESS Toll Free 1-800-422-BUSS • TDD/TTY (360) 377-9874



Mason Transit
2505 Olympic Hwy N., Suite 140 • Shelton, WA 98584
(360) 427-5033 • Toll Free 1-800-374-3747 • TDD/TTY (360) 427-0268



Metro Transit
201 S. Jackson Street • Seattle, WA 98104-3856
(206) 553-3000 • Toll Free 1-800-542-7876 • TDD/TTY (206) 684-1739



Pierce Transit
The Bus Shop • 930 Commerce • Tacoma, WA 98402
The Bus Shop • 3720 96th Street SW • Lakewood, WA 98499
(253) 581-8000 • Toll Free 1-800-562-8109 • TDD/TTY (253) 582-7951
SHUTTLE (253) 581-8100 • Toll Free 1-800-841-1118 • TDD/TTY (253) 582-7963



Skagit Transit
600 County Shop Lane • Burlington, WA 98233-9772
Burlington: (360) 757-8801 • Mount Vernon: (360) 757-4433 • TDD/TTY (360) 757-1938



Sound Transit
401 S. Jackson Street • Seattle, WA 98104
(206) 398-5000 • Toll Free 1-800-201-4900 • TDD/TTY 1-888-713-6030



Washington State Ferries
Customer Information • 2911 Second Avenue • Seattle, WA 98121-1012
(206) 464-6400 • Toll Free WA only 1-888-808-7977
Toll Free WA only automated line 1-800-84-FERRY
TDD/TTY 1-800-833-6388 • Braille 1-800-833-6385

The Regional Reduced Fare Permit is a cooperative program developed through the Puget Sound Regional Council with support from the Federal Transit Administration and public agencies in the Puget Sound region.

Application for Regional Reduced Fare Permit for Senior and Disabled Persons

(this application is available in accessible format)

Processing Fee \$3

Please Print

For Office Use Only	
ID#	_____
PCA	_____
<input type="checkbox"/>	Temporary
<input type="checkbox"/>	Permanent
Date	_____

Name _____
First Middle Last

Address _____
Street City State ZIP

Date of Birth _____ Phone No. _____

Please read the applicant section of the Medical Eligibility Criteria and Conditions brochure before completing this application.

I am applying for a Regional Reduced Fare Permit on the following basis. Please check only one.

- I am 65 years of age or older.
- I am providing proof of eligibility and am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability. (For issuance of a Temporary Regional Reduced Fare Permit only.)
- I am providing proof of current eligibility by the Veterans Administration as having a disability of at least 40%
- I am presenting a valid Medicare card issued by the Social Security Administration. (For issuance of a Temporary Regional Reduced Fare Permit only.)
- I am providing a valid Regional ADA paratransit card, issued by _____ Agency
This ADA paratransit card expires _____
- I am providing a valid ADA paratransit card from outside the region. (For issuance of a Temporary Regional Reduced Fare Permit only.)
- I have an obvious physical impairment(s) meeting one or more of the medical criteria listed in the Medical Eligibility Criteria and Conditions brochure.
- I am currently enrolled by a Washington State Individual Educational Program (IEP). (For issuance of a Temporary Regional Reduced Fare Permit only.)
- I am medically disabled as certified by a Physician, Psychiatrist, Psychologist (Ph.D.), Physician's Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.) or Audiologist, licensed in the State of Washington. See Health Care Providers Certification form on the reverse side of this application. This agency reserves the right to contact our Health Care Provider for verification.

Applicant's Signature _____ Date _____

Community Transit
Everett Transit
Intercity Transit

Jefferson Transit
Kitsap Transit
Mason Transit

Metro Transit
Pierce Transit
Skagit Transit

Sound Transit
Washington State Ferries

Regional Reduced Fare Permit — Certification of Eligibility

Applicant's Release — Please Print

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 the transit agency issuing this permit shall have the right and opportunity to verify my eligibility for a Regional Reduced Fare Permit. 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 Regional Reduced Fare Permit and be subject to criminal prosecution in accordance with Washington State Law for fraud (RCW #9A.56.020).

Name _____
First Middle Last

Address _____
Street City State ZIP

Date of Birth _____ Phone No. _____

Applicant's Signature _____ Date _____

This Section To Be Completed By The Following Approved Health Care Provider:

Washington State Licensed:

- Physician (M.D.) • Psychiatrist • Psychologist (Ph.D.) • Audiologist certified by the American Speech, Language and Hearing Association • Physician's Assistant (P.A.) • Advanced Registered Nurse Practitioner (A.R.N.P.) • Signatures of Health Care Providers other than these are not acceptable.

Instructions:

1. This applicant must meet at least one of the criteria and conditions listed in the Medical Eligibility Criteria and Conditions brochure.
2. The specific Medical Eligibility Criteria number must be noted in the space provided.
3. 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.
4. An applicant's financial situation has no bearing on eligibility.

I certify that _____ meets the Medical Eligibility Criteria _____
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 at 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 No. _____

Provider or Agency Address _____

Washington State License No. _____

Signature _____ Date _____

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 fraud (RCW #9A.56.020).

This application is not to be duplicated.

SELF AWARENESS INVENTORY

√ If skill is attained to identified level of completion
 → If skill attainment continues into next year

I understand...	Ages:						
	14	15	16	17	18	19	20
• What my disability is							
• The educational and physical implications of my disability							
• My health needs							
• My need for physical & educational accommodations for work, school, and community							
• How to communicate my needs to others							
• My strengths and needs							
• How to communicate my likes and dislikes							
• How to get along with others							

I can...							
	14	15	16	17	18	19	20
• Identify my interests and abilities							
• Demonstrate knowledge of physical care							
• Express feelings of self worth; accept and give praise and criticism appropriately							
• Recognize authority & follow instructions							
• Make and maintain friendships							
• Demonstrate self-organization							
• Anticipate consequences							

I can demonstrate this self awareness...							
	14	15	16	17	18	19	20
• In school / with teachers and friends							
• At home / with parents and siblings							
• At work / with supervisor and peers							
• In community situations							

Notes / Additional Information

SUGGESTED ENCLOSURES:
 Self-description of Disability(s)
 Inventory of Health Needs and Modifications
 List of Necessary Accommodations, Modifications, Adaptations
 Learning Styles & Social Skills Assessment Information

ADDITIONAL RESOURCES:
 Independent Living Center & Advocacy Projects

COMMUNITY PARTICIPATION INVENTORY

√ If skill is attained to identified level of completion
 → If skill attainment continues into next year

I am able to...	Ages:						
	14	15	16	17	18	19	20
• Find grocery stores, theaters, libraries, etc.							
• Participate in religious activities							
• Order food at restaurants							
• Schedule needed appointments							
• Participate in clubs / community organizations							
• Register for selective services (males only)							
• Vote and know where to go to do so							
• Call 911 or other personnel in an emergency							
• Demonstrate my knowledge of citizen and civil rights and responsibilities							
• Know the nature of local, state, and federal governments							
• Demonstrate my knowledge of the law and ability to follow the law							
• Know the availability of community resources							
• Choose and plan activities							
• Demonstrate my knowledge of traffic rules and safety							
• Understand and demonstrate appropriate behavior in public places							
• Use social courtesies and respond to social situations							
• Find familiar locations							

I get around my community by...	14	15	16	17	18	19	20
• Walking							
• Bike							
• Bus							
• Taxi							
• Transit							
• Driving a vehicle							
• Depending on others / alternate means							

Notes / Additional Information

SUGGESTED ENCLOSURES:
 Community Participation Assessment Information

ADDITIONAL RESOURCES:
 Independent Living Center

FINANCIAL INVENTORY

√ If skill is attained to identified level of completion
 → If skill attainment continues into next year

I need information on the following...

- General Public Assistance
- AFDC (Aid to Families with Dependent Children)
- Food Stamps
- SSI (Supplementary Security Income)
- Trust/Will
- Insurance
- Taxes

Ages:						
14	15	16	17	18	19	20

I am able to...

- Open and balance a savings account
- Open and balance a checking account
- Understand loan information
- Develop a budget
- Identify money and make correct change
- Understand financial documents:
 - ~ credit/debit cards
 - ~ payment plans
 - ~ check stubs
 - ~ bills
- Use banking services

I know where to go or who to contact for...

- Banking needs
- Medical assistance and appointments
- Transit
- Insurance needs
- Emergency needs

Notes / Additional Information

SUGGESTED ENCLOSURES:
 Correspondence to and from Agencies
 Contact People and Phone Numbers
 Copies of Records/Policies and Numbers
 Budget & Loan Records
 Credit Card Applications/Numbers

ADDITIONAL RESOURCES:
 Independent Living Center
 County Social Services

INDEPENDENT LIVING INVENTORY

√ If skill is attained to identified level of completion
 → If skill attainment continues into next year

I plan to live...

- Alone and independent
- With friends or spouse (including college dorm)
- With parents or other relatives
- In supervised setting, group home

Ages:						
14	15	16	17	18	19	20

I plan to live in a...

- Rural setting or small town
- Large city
- Metropolitan area

14	15	16	17	18	19	20

Let's talk about...

What I do with time...

- Manage my time correctly
- Get up in the morning on time
- Use good judgment about going to be on time

14	15	16	17	18	19	20

How I take care of myself...

- Do my own hygiene and grooming
- Select and care for my own clothes
- Do my own laundry/use machines at Laundromat
- Establish daily / weekly routine
- Walk safely in traffic areas
- Seek help when problems occur
- Avoid harm from strangers or unfamiliar situations
- Ride safely in a vehicle
- Make choices about sex, drugs, and alcohol

14	15	16	17	18	19	20

On my own, I can...

- Make menus, formulate grocery list
- Do grocery shopping and purchase food
- Practice comparison shopping
- Prepare meals in microwave/crockpot
- Follow recipe and directions in meal prep
- Set table
- Clean kitchen after meal & wash dishes

14	15	16	17	18	19	20

Getting my own apartment/housing—I can...

- Find & select adequate housing
- Understand rental/purchase agreements
- Make arrangements for public utilities
- Do household maintenance
- Complete household chores & cleaning tasks

14	15	16	17	18	19	20

**INDEPENDENT LIVING (Continued)
INVENTORY**

√ If skill is attained to identified level of completion
→ If skill attainment continues into next year

Ages:

Getting my own apartment/housing—I can... (continued)

- Manage household safety & security
- Apply simple first aid
- Administer medications
- Handle telemarketers / junk mail
- Maintain home interior / exterior
- Use basic appliances & tools

14	15	16	17	18	19	20

Money, Money, Money—I can...

- Understand and use credit cards
- Balance my checkbook and bank statement
- Set up a budget and pay bills
- Understand rental costs/deposits/hook up fees
- Shop for clothes and household goods

14	15	16	17	18	19	20

I need to arrange for...

- Personal assistance (attendant care)
- Assistive technology
- Special equipment
- Subsidized housing

14	15	16	17	18	19	20

Notes / Additional Information

SUGGESTED ENCLOSURES:
Independent Living Assessment Information
Insurance Agents (Names & Numbers)
Bank Officer (Names & Numbers)

ADDITIONAL RESOURCES:
Independent Living Center

INDEPENDENT LIVING (continued)
INVENTORY

Notes / Additional Information

SUGGESTED ENCLOSURES:

Resume
Letters of Recommendations
Job Applications
Job Evaluations
Video Tapes of Interviews
Job Experience and Volunteer Work
Career Outlook

ADDITIONAL RESOURCES:

Transition Guidebook
Job Service
Vocational Rehabilitation

**POST-SECONDARY
INVENTORY**

√ If skill is attained to identified level of completion
 → If skill attainment continues into next year

I am interested in attending a...

- 2-year Community College
- Job Corp
- Technical / Vocational College
- 4-year College or University
- Trade or Business School
- Military

Ages:

14	15	16	17	18	19	20

I need information on...

- Career Programs
- Financial aid
- Disability Support Services
- Accessibility
- Assistive Technology
- College services and programs
- Career opportunities & wages
- The role of Voc Rehab & Job Services

14	15	16	17	18	19	20

I have...

- Visited the campus of choice
- Arranged for financial aid
- Visited with Disability Support Services
- Sent relevant information from high school to the college of choice
- Transferred appropriate medical / dental records
- Arranged transportation
- Become acquainted with the community

14	15	16	17	18	19	20

Notes / Additional Information

SUGGESTED ENCLOSURES:
 List of Institutions Visited/Contact People
 Copies of Applications
 Entrance Exam Results
 Financial Aid Information
 Career Outlook

ADDITIONAL RESOURCES:
 College and or University Student Support Services
 Transition Guidebook
 Vocational Rehabilitation
 Job Service

ACADEMIC/EDUCATIONAL INVENTORY

√ If skill is attained to identified level of completion
 → If skill attainment continues into next year

I...	Ages:						
	14	15	16	17	18	19	20
<ul style="list-style-type: none"> Understand the purpose and process of the IEP meetings Attend my IEP meetings Participate in my IEP meetings Invite others to attend my IEP meetings Facilitate my IEP meetings 							

I...	Ages:						
	14	15	16	17	18	19	20
<ul style="list-style-type: none"> Choose classes most appropriate for my disability and goals Have an understanding of academic impact of classes I take Understand my CTBS scores and their impact on classes I take Have taken the ACT/SAT in preparation for post secondary 							

I...	Ages:						
	14	15	16	17	18	19	20
<ul style="list-style-type: none"> Have completed vocational and interest inventories Have participated in work experiences in the community Have talked with my parents and others about career decisions Review and understand my grades and IEP goals / objectives each quarter 							

Notes / Additional Information

SUGGESTED ENCLOSURES:

- Current IEP
- Current Community or Vocational Assessment
- Recent Standardized Test Scores (CTBS, ACT/SAT)
- School Transcript

