REDUCED FARE ID APPLICATION

SECTION I – APPLICANT INFORMATION

Today's Date _____

Last Name | First Name | Middle Initial

Mailing Address | Apt/Unit# | City | State | Zip Code

( )

Phone Number with Area Code | Date of Birth (month/day/year) | Email Address

Check only one:

❑ Youth (Ages 6 through 18) ❑ Senior (Ages 65 and older) ❑ Medicare Cardholder ❑ Persons with a Disability

Check the appropriate box:

❑ New card - $5.00 ❑ Lost card - $2.50

SECTION 2 – TERMS AND CONDITIONS (TO BE SIGNED BY APPLICANT)

I certify to the best of my knowledge that the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated. I understand that my Valley Metro Reduced Fare ID card is not transferable to other persons and that Valley Metro reserves the right to determine qualifications for issuing cards in accordance with the terms and conditions listed on the application instruction sheet. I understand the Valley Metro Reduced Fare ID card is valid until the date printed on the card and that I must reapply at that time if I wish to continue my eligibility with the Valley Metro Reduced Fare ID program. I understand that I must present this card when requested by a bus operator or fare inspector to verify eligibility for the reduced fare. I understand that the information on this application will be kept confidential by the professionals involved in evaluating my eligibility. I understand that Valley Metro may contact the physician or licensed health care professional listed on my application to verify my qualifying disability. I authorize the certifying physician or licensed health care provider to provide all information needed to Valley Metro in determining my eligibility for the Valley Metro Reduced Fare program. **By signing below, you certify that you have read and understand the terms and conditions of this program:**

SIGN

Applicant Name (Print) | Applicant Signature | Date

FOR OFFICE USE ONLY

Card# _____ Expiration _____ Documentation _____

Site Location: _____ Outlet Rep Initials: _____

RPT1635/4-2012

SECTION 3 – QUALIFIED SIGNEES FOR MEDICAL PROFESSIONAL CERTIFICATION

Qualified healthcare professionals who may certify disabilities listed in **SECTION 4—check one that applies:**

- ❑ Audiologist – Hearing impairments
- ❑ Certified Orientation and Mobility Specialist – Visual impairments
- ❑ Chiropractors – Mobility impairments
- ❑ Clinical Psychiatrists and/or Psychologists – Mental impairments & drug and alcohol addiction
- ❑ Licensed Social Worker – Mental/Cognitive impairments
- ❑ Medical Doctor (MD) and Doctor of Osteopathy (DO) – All impairments
- ❑ Nurse practitioner – All impairments
- ❑ Occupational Therapist – Mobility impairments—upper and lower extremities (activities of daily living)
- ❑ Optometrist or Ophthalmologist – Visual impairments
- ❑ Physical Therapist – Mobility impairments
- ❑ Physician's Assistant – All impairments
- ❑ Podiatrist – Mobility impairments
- ❑ Recreational Therapist – Mental or mobility impairments
- ❑ School Psychologist or Special Education Teacher – Mental/Cognitive impairments
- ❑ Substance Abuse Program Director - Drug and alcohol addiction
- ❑ Other - Please list title: _____

SECTION 4 – MEDICAL DISABILITY CRITERIA

In order to qualify for a Valley Metro Reduced Fare ID card, your client/patient listed on this application must have a physical or mental/cognitive condition that falls within the medical eligibility criteria listed below that substantially limits a major life activity, such as caring for one's self, walking, seeing, hearing, speaking, breathing, learning, and/or working, and that further meets legal standards for reduced fare eligibility listed on page one of this application.

Is this disability permanent? ❑ Yes ❑ No If no, how long do you expect this disability to last?

_____

Note: If a disability is temporary, it must last for at least 90 days to be eligible for a reduced fare.

Check all that apply:

❑ NON-AMBULATORY DISABILITIES

Impairments which require the individual to use a wheelchair, electric scooter, or other mobility device.

❑ SEMI-AMBULATORY PHYSICAL DISABILITIES

- ❑ **Restricted mobility.** Disability requiring the use of a cane, crutches, long leg braces, service animal, white cane, walker, or other orthopedic appliances.
- ❑ **Arthritis.** American Rheumatism Association criteria may be used as a guideline for the determination of arthritic disability. Therapeutic Grade III, Functional Class III, or Anatomical State III or worse is evidence of arthritic disability.

❑ **Loss of extremities.** Anatomical deformity of or amputation of one or both hands, arms, feet, or legs, or loss of major motor function.

❑ **Cerebrovascular accident.** Ongoing debilitating effects following occurrence of cerebrovascular accident.

❑ **Cardiopulmonary disease.** Serious loss of heart or lung reserves as shown by x-ray, EKG or other tests and in spite of medical treatment there is breathlessness, pain or fatigue. If diagnosis is asthma, please state whether: Individual has been on systemic medication for the immediate past six months, or has been required to use fast acting inhaler for three or more episodes per week for the immediate past six months. A specific diagnosis is required, please specify:

_____

❑ **Dialysis.** Individual who must use a kidney dialysis machine in order to live.

❑ **Epilepsy, grand mal or psychomotor.** Persons who are seizure-free for a continuous period of six months are disqualified unless they are restricted from driving a motor vehicle.

❑ **Neurological disabilities.** Neurological and physical impairments not controlled by medication (i.e. cerebral palsy, multiple sclerosis or traumatic brain injury).

❑ **Stroke.** Individual has substantial functional motor deficits in any of two extremities, loss of balance and/or cognitive impairments three months post stroke.

❑ **Other** (Please specify):

_____

❑ VISUAL DISABILITIES

❑ **Legally blind.** Visual impairment that is bilateral and not correctable with lenses. Individual's visual acuity in the better eye, with correction, is 20/200 or less.

❑ **Contraction of visual field.** Individual whose widest diameter of visual field subtends an angular distance of 20 degrees, less than 10 degrees from point of fixation, or whose visual field efficiency is 20 degrees or less.

❑ HEARING DISABILITIES

Total deafness. Individual whose hearing loss is 70 dba or greater in the 1000 and 2000 Hz ranges and not correctable with hearing aids.

❑ MENTAL OR COGNITIVE DISABILITIES

A principal diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV classification in one of the following areas is required for eligibility: Organic Mental Disorders, Schizophrenic Disorders, Paranoid Disorders, Psychotic Disorders not elsewhere classified, Affective Disorders, Somata Form Disorder, Dissociative Disorders, Adjustment Disorders, Psychological Factors affecting physical condition, and Post-Traumatic Stress Syndrome.

These diagnoses must be at Class III to V levels, as follows:

- ❑ Class III – Moderate impairment. Levels compatible with some, but not all, useful functions.
- ❑ Class IV – Marked impairment. Levels significantly impede useful functioning.
- ❑ Class V – Extreme impairment. Levels preclude useful functioning.

❑ **Autism.** Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli and very inadequate social relationships.

❑ **Developmentally disabled.** Cognitive disability that originates before the age of 18.
❑ **Adult mental retardation.**
❑ **Mental illness.** Individual whose mental illness includes a substantial disorder of thought, perception, orientation, or memory that impairs judgment and behavior. A specific diagnosis is required, please specify:

❑ CHRONIC PROGRESSIVE DEBILITATING CONDITIONS

Individual who experiences debilitating diseases, autoimmune deficiencies, or progressive and uncontrollable malignancies, any of which are characterized by fatigue, weakness, pain and/or changes in mental status that impairs mobility.

- Advanced connective tissue disease such as Lupus, Eythematousus, Sclermodema or Polyarteritis Nodosa
- Symptomatic HIV: (AIDS or ARC) in CDC defined clinical group IV, Subgroups A—E

A specific diagnosis is required, please specify:

❑ DRUG AND ALCOHOL DEPENDENCY

An authorized Substance Abuse/Alcohol Rehabilitation facility or agency must be licensed with the State of Arizona, a local city or within Maricopa County. The facility must have a license number or a tax I.D. number to operate the facility or business and must provide a drug and alcohol program or after care program, which includes:

- Applicant living at a drug treatment facility or transitional living facility or receiving rehibilitation services from a licensed drug or alcohol treatment center.
- Applicant is actively participating in a drug treatment program
- Attending 12-step meetings
- Subject to random drug testing
- Receiving career counseling and/or seeking employment

NOTE: In order for applications for drug and alcohol dependency to be accepted, the drug and alcohol treatment center or transitional living facility must be registered with Valley Metro prior to submitting an application on behalf of their client. To register, please contact Valley Metro at (602) 716-2100, option 1.

❑ OTHER DISABILITY

Any other temporary or permanent disability that would significantly affect the applicant's ability to effectively use mass transportation services or a mass transportation facility without special facilities, planning or design. A specific diagnosis is required, please specify:

SECTION 5 – QUALIFIED HEALTHCARE PROFESSIONAL INFORMATION

Do not submit applications for individuals who do not qualify for a medical disability under Valley Metro's Reduced Fare Program. Reduced fare ID cards are not issued for socioeconomic purposes. The medical disability must be identified in Title 49 CFR 609.3—Definitions and must further meet Valley Metro requirements for reduced fare eligibility.

The licensed professional signing this application must attach or provide one of the following types of supporting documentation to authenticate the diagnosis listed on the application:

❑ A signed prescription slip or medical record form that matches the diagnosis listed on the application

❑ A description of the diagnosis on the agency or healthcare provider's letterhead that matches the diagnosis on the application. This document must be an original and it must be signed by the professional listed on the application. **These documents must be dated within the past 30 days.**

Name of Medical Practice or Certifying Agency

Qualified Healthcare Professional's Name | Title | License Number

Street Address | City | State | Zip

Phone Number | Fax Number

I certify that I am a qualified healthcare professional that fits the criteria listed under **SECTION 3**. I certify the applicant is disabled as defined by the above criteria, and the information I have provided is true and correct under penalty of perjury according to the laws of the State of Arizona.

SIGN

Authorized Signature | Date