MILWAUKEE COUNTY TRANSIT SYSTEM
REDUCED FARE ID APPLICATION

For Office Use Only

Card Issued (date) _____ Card Renewal (date) _____ Card # _____

Comments _____ Staff Initials _____

PLEASE FILL OUT ALL APPLICABLE SECTIONS

Last Name First Name Middle Initial

Street Address Apt. # / Lot #

City State Zip Code Area Code + Phone Number

___/___/___
Month Day Year of Birth

An applicant can qualify for the Reduced Fare Program based on age or disability. Please check the appropriate box:

- ☐ I am age 6 to 11. (Provide proof of age.)
- ☐ I am age 65 or older. (Provide proof of age.)
- ☐ I am currently covered under Medicare. (Bring Medicare card. Forward card **NOT** accepted.)
- ☐ I have a physical or mental impairment, which meets the FTA definition (609.3) of a handicapped person, as listed below. (Treating physician must complete back page.)
- ☐ I am an eligible Transit Plus client (Bring Transit Plus ID.)

"***Handicapped persons*** means those individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected".

"***Disability*** means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work.

I certify that, to the best of my knowledge, the information given on this application is true and accurate.
I understand that MCTS will rely upon this information when determining eligibility for the Reduced Fare Program. I understand that providing false or misleading information will result in my eligibility being revoked. Allowing individuals, other than myself, to utilize this card will also result in revocation.

I hereby authorize the release, either verbally or in writing, of any disability-related medical information to MCTS. I understand that this information may be used in conjunction with this application when determining my eligibility for the Reduced Fare Program through MCTS, and will not be released without my written authorization.

Applicant Signature _____ Date _____

Applicant must provide photo ID

MUST BE COMPLETED BY TREATING PHYSICIAN OR LICENSED HEALTH CARE PROVIDER (WI MEDICAL LICENSE)

To qualify for an MCTS Reduced Fare Card, your patient(listed on reverse side) must have a disability that falls within the eligibility criteria listed below. Certain conditions do not qualify, i.e., pregnancy, obesity, drug/alcohol addiction, controlled epilepsy. **Please check all that apply.**

Is the impairment permanent? ☐ Yes ☐ No If no, duration of impairment _____

☐ Applicant's impairment DOES NOT MEET any of the functional limitations listed above. Therefore, I cannot certify that the applicant's impairment meets the eligibility criteria for receiving an MCTS Reduced Fare Card.

Please Print: All information in this box MUST be provided by treating physician or licensed health care provider (WI Med Lic).

A. Non-Ambulatory:

□ 1. Impairment which requires individual to use a wheelchair or similar mobility device.

B. Semi-Ambulatory:

□ 1. **Arthritis -** American Rheumatism Assoc. may be used as a guideline for the determination of disability**;** Therapeutic Grade III, Functional Class III, Anatomical State III, or worse is evidence of arthritic disability.

□ 2. **Loss of Extremities -** Anatomical deformity of or amputation of hand(s) and/or feet, or loss of major function.

□ 3. **Cerebrovascular Accident -** Ongoing debilitating effects following occurrence of CVA, or effects of Cerebral Palsy.

□ 4. **Cardio-pulmonary -** 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.

□ 5. **Dialysis -** Individual who must use a kidney dialysis machine to sustain life.

□ 6. **Other** _____
(Diagnosis)

How does this affect mobility? _____

_____

_____

C. Visual Impairment:

□ 1. **Legally Blind -** Visual impairment that is bilateral and **not** correctable with lenses.

□ 2. **Contraction of Visual Field -** Persons whose widest diameter of visual field subtends an angular distance of 20 degrees, or less than 10 degrees from point of fixation, or whose visual field efficiency is 20 degrees or less.

D. Hearing Impairment:

□ 1. **Legally Deaf -** Hearing impairment that is bilateral and **not** correctable by hearing aid.

E. Cognitive Impairment:

□ 1. **Developmentally Disabled -** Cognitive disability that originates before 18.

□ 2. **Adult Intellectual Disability**

□ 3. **Autism -** Monotonously repetitive motor behavior with severe withdrawal, inappropriate response to stimuli, or very inadequate social relationships.

□ 4. **Schizophrenia**

□ 5. **Organic Brain Syndrome/Bi-Polar -** Cognitive disturbances that require boarding or home care, funded work activity or workshop.

F. Neurological Disabilities:

□ 1. **Cerebral Palsy -** Impairment not controlled with medication.

□ 2. **Multiple Sclerosis -** Impairment not controlled with medication.

□ 3. **Epilepsy -** Grand Mal or Psychomotor; Persons who are seizure-free for period of **six** months do not qualify.

G. Other Disability: _____
(Diagnosis)

How does this impact ability to use transit? _____

_____

_____

_____

_____

_____
Physician's / Health Care Provider's Name State License Number (Required)

_____
Office Address City State Zip Code

_____
Area Code + Phone Number Area Code + Fax Number

I certify that the applicant (listed on reverse side) has a disability as defined by the above criteria, and that the information I have provided is true and correct. The applicant is currently under my care for the disabilities listed above.

_____
Authorized Signature **Date**