



## Milwaukee County Transit System Reduced Fare Program

Dear Reduced Fare Applicant:

Thank you for your interest in the Milwaukee County Transit System Reduced Fare Program. This program offers a discounted fixed-route bus fare to qualified individuals. There are three categories used to determine eligibility:

1. Individual is aged 65 or older.
2. Individual is currently covered under **Medicare** (Medicaid not applicable).
3. Individual must have a qualifying physical or mental impairment (see back of application for details).

The application process:

- Complete and sign the front of the application.
- Have your **treating** physician or licensed health care provider (**WI Medical Lic.**) complete and sign the back of the application.
- Bring your completed application to our office located at 1942 N. 17<sup>th</sup> Street, Milwaukee, WI 53205, between the hours of 8:30am and 3:30pm, Monday thru Friday, to have your photograph taken and receive your Reduced Fare ID Card. **Bring a photo ID with you (i.e., drivers license, state ID, etc.).**

**Please note:** The following will negate the application:

- Inaccurate or incomplete information on the application.
- Lack of medical verification from either **treating** physician or licensed health care provider (WI Medical Lic).
- Failure to provide required photo identification.

There is no cost to the applicant for the initial Reduced Fare ID card, however if the card is lost or stolen, a replacement card will be issued at a cost of \$10.00. Your Milwaukee County Reduced Fare Card is to be used exclusively by you. Allowing others to use it is prohibited, and will result in the immediate loss of eligibility.

**Any questions or concerns regarding the Reduced Fare Program, please call the Milwaukee County Transit System at (414) 344-4550 Ext. 3592.**



**MILWAUKEE COUNTY TRANSIT SYSTEM  
REDUCED FARE PROGRAM APPLICATION**

**For Office Use Only**

Card Issued (date) \_\_\_\_\_ Card Renewal (date) \_\_\_\_\_ Card # \_\_\_\_\_  
Comments \_\_\_\_\_ Staff Initials \_\_\_\_\_

**FRONT AND BACK OF APPLICATION MUST BE COMPLETED TO PROCESS**

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Street Address Apt. # / Lot #

\_\_\_\_\_  
City State Zip Code Area Code + Phone Number

\_\_\_\_\_  
Month / Day / Year of Birth Social Security Number

Check the appropriate box and sign below:

- I am age 65 or older (have proof of age).
- I am currently covered under Medicare (bring Medicare card with you).
- I have a physical or mental impairment, which meets the FTA definition (609.3) of a handicapped person, as listed below.

*“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, 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 thru 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 physical or mental impairment 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 \_\_\_\_\_

**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 Mental Retardation**
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.

- 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).**

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) is disabled as defined by the above criteria, and that the information I have provided is true and correct. I am currently treating the applicant for the disability(s) indicated above.**

Authorized Signature

Date