MILWAUKEE COUNTY TRANSIT SYSTEM
REDUCED FARE ID 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 __________________________

/ / / Month Day Year of Birth __________________________ Social Security Number

There are 3 ways an applicant can qualify for the Reduced Fare Program. Please check the appropriate box listed below:

☐ I am age 65 or older. (Have 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.)

“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

TP51 (05/17)
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

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? ____________________________

□ Applicat’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).

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<tr>
<th>Physician’s / Health Care Provider’s Name</th>
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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: ____________________________