

REDUCED FARE PROGRAM APPLICATION FOR A PERSON WITH A DISABILITY

PART 1 - TO BE COMPLETED BY APPLICANT (PLEASE PRINT)

_____	_____	_____
Last Name	First Name	M.I.
_____	_____	_____
Street Address	Apt. #	City
_____	_____	_____
Phone Numbers	_____	_____
Home	Cell	Other
Sex: _____ Male _____ Female	Social Security #: _____	_____
Date of Birth: _____	Height: _____	Weight: _____

I am applying for a SCAT reduced fare ID card because:

- | | |
|--|--------------|
| | Check
One |
| A. I am over 65 years old
Requires a valid driver's license, Ohio ID, or Birth Certificate upon application. | _____ |
| B. I have a Medicare Card
You must have your Medicare card (red, white & blue) and some form of picture ID upon application (Ohio Medicaid recipients do not automatically qualify) | _____ |
| C. I have a legally documented disability
You must have a physician fill out Part II. | _____ |

I certify that the information provided is true and agree to release this information to SCAT for the purpose of obtaining a Reduced Fare ID card. I understand that the card is for my personal use and will not be transferred to any other person. I grant SCAT permission to verify the information given on Parts I and II of this form. I also grant permission to SCAT to photograph me for the purpose of obtaining a photo ID card.

Signature of Applicant

Date



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Part II - To be completed by a licensed physician only

To be eligible for the SCAT Reduced Fare Program, your patient/client must have a physical or mental condition that falls within the medical criteria listed below. If you confirm that the patient/client is physically or developmentally disabled, that person will be eligible for reduced fares on Springfield City Area Transit's public bus service. Persons will not be eligible for reduced fares if their sole capacity is pregnancy, obesity, and acute or chronic condition due to drugs, alcohol, or any contagious disease. All information provided will be held confidential. Application must be completely filled out. If any section is not complete the application will be determined incomplete and will not be processed. Mail application directly to: Springfield City Area Transit, Certification Processing, P.O. Box 1265, Springfield, Ohio 45501.

Physical Disabilities

_____ **1. Non-Ambulatory Disabled**

Disability that will not allow that person to walk, even with the assistance of devices, but with or without the assistance of a personal care attendant (PCA), has the personal mobility and independence in a wheelchair that use of appropriate public transportation services is a reasonable expectation.

_____ **2. Semi-Ambulatory Disabled**

Disability that will not allow that person to walk without the assistance of walkers, crutches, canes, braces, artificial legs, or other such adaptive device, and for whom use of appropriate public transportation services is a reasonable expectation.

_____ **3. Loss of Extremities**

Anatomical deformity, amputation of both hands, one hand and one foot, or loss of major function.

_____ **4. Cerebrovascular Accident**

Ongoing debilitating effect which follows an occurrence of a cerebrovascular accident.

_____ **5. Cardio-pulmonary 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.

_____ **6. Dialysis**

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

Visual Disabilities

_____ **1. Legally Blind**

Visual impairment that is bilateral and not correctable with lenses.

_____ **2. Contraction of Visual Field**

Person whose widest diameter of 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.

Hearing Disabilities

_____ **1. Legally Deaf**

Hearing impairment that is bilateral and not correctable with a hearing aid.

1. Mental Disabilities

_____ **1. Developmentally Disabled**

Mental disability that originated before age 22.

_____ **2. Adult Mental Retardation**

State of significant subnormal intellectual development with reduction of social competence

in a person to the extent that the person requires care and treatment for his/her own welfare and the welfare of others in the community.

_____ **3. Epilepsy**

Grand Mal or Psychomotor. People who are seizure-free for a continuous period of six months are disqualified.

_____ **4. Autism**

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

_____ **5. Neurological Disabilities**

Neurological and physical impairments not controlled by medication such as cerebral palsy

or multiple sclerosis.

_____ **6. Organic Brain Syndrome/Emotionally Disturbed**

Chronic illness/disturbance that requires boarding or care home, funded work activity or workshop. **MUST CHECK ONE OF THE FOLLOWING WHICH BEST DESCRIBES PATIENT.**

_____ **High:** exhibits symptoms of severe mental illness that does not significantly interfere with daily functioning.

_____ **Low:** exhibits symptoms of severe mental illness with such severity that daily functioning is frequent and requires intense community based services which includes community psychiatric support and treatment providers, pharmacological management, psychiatrist assessment, individual therapy and group therapy.

Is the disability permanent? Yes _____ No _____

If temporary, please list estimated number of months of temporary disability: _____

I hereby certify that the applicant, _____ is disabled as defined by the preceding criteria and that the information contained on this form is true.

Physician Signature

Date

Physicians Name

Telephone

Address: _____

Licensing Identification #

FOR OFFICE USE ONLY

Date Received: _____ Approved _____ Expiration Date: _____

Denied _____ Incomplete _____ Reason: _____

Signature: _____ Date: _____

APPEALS PROCESS

Applicants who believe their application for the Reduced Fare Program has been erroneously denied may appeal such determination to the Paratransit Services Certification Supervisor by submitting a **written statement of appeal** to:

Springfield City Area Transit
Certification Supervisor/Glen Massie
P.O. Box 1265
Springfield, Ohio 45501

Springfield City Area Transit designee will, within 15 days of receipt of statement of appeal, meet either in person or via phone conversation with the applicant to discuss the application and the reason why such applicant believes he/she should be eligible for the Reduced Fare Program. Within 10 days, the Springfield City Area designee will make a final determination as to whether the applicant is eligible for the Reduced Fare Program and will send notice of such determination to the applicant in writing.