

APPLICATION FOR MBTA TRANSPORTATION ACCESS PASS1. PLEASE PRINT. COMPLETE SECTION A BELOW:

PART A: APPLICANT INFORMATION (PLEASE PRINT)			
NAME:		DATE:	
STREET ADDRESS		YEAR OF BIRTH:	
CITY	STATE:	ZIP:	RENEWAL: YES _____ NO _____
TELEPHONE: ()	EMAIL ADDRESS:		
IN CASE OF AN EMERGENCY, PLEASE NOTIFY:		TELEPHONE:	

2. COMPLETE PART B ON THE NEXT PAGE. If you are: • A Medicare Card holder, • A current customer of THE RIDE, • A current recipient of services through the Massachusetts Department of Mental Health, or the Massachusetts Department of Mental Retardation, or • A Veteran with a disability rating of 70% or greater, it is not necessary to have Part C completed. Simply complete Parts A and B, and submit this application to the MBTA for processing (Go to # 4 below).

3. If you are not in one of the categories mentioned in #2 above, you must bring this application to a licensed/certified health care professional to complete part C for health care certification.

Examples of licensed/certified health care professionals include those who are familiar with your disability and are licensed or certified in their field, such as Medical Doctor, Licensed Social Worker, Psychologist, Audiologist, Registered Nurse, Psychiatrist.

4. Once this application is completed, return it to the address below. The MBTA will review the information to determine your eligibility.

YOU WILL RECEIVE NOTIFICATION IN THE MAIL WITHIN 21 DAYS.

**MBTA SENIOR AND ACCESS PASS PROGRAM
BACK BAY STATION
145 DARTMOUTH STREET
BOSTON, MA 02116-5162
(617)222-5438/VOICE, (617)222-5854/TTY**

PART B: TO BE COMPLETED BY APPLICANT

CHECK ONLY **ONE** OF THE FOLLOWING:

I AM A MEDICARE CARD HOLDER. I HAVE ATTACHED A PHOTOCOPY OF MY CARD.

(Please note: MassHealth is **not** the same as Medicare. Do not attach a copy of MassHealth Card).

I AM A CURRENT RECIPIENT OF SERVICES THROUGH THE MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH (DMH) AND/OR DEPARTMENT OF MENTAL RETARDATION (DMR). I HAVE ATTACHED AN ORIGINAL LETTER FROM AN AUTHORIZED REPRESENTATIVE OF DMH/DMR WHICH CONFIRMS MY STATUS AS A DMH/DMR CLIENT.

I AM A CURRENT CUSTOMER OF THE MBTA PARATRANSIT SERVICE: "THE RIDE." MY RIDE ID NUMBER IS: _____.

(Please note: We are **not** referring to your old pass. Do not write in an ID number from the pass you are renewing).

I AM A VETERAN WITH A DISABILITY RATING OF 70% OR GREATER. I HAVE ATTACHED AN ORIGINAL LETTER FROM THE VA, SIGNED BY A VETERAN'S SERVICES OFFICER, WHICH SPECIFIES MY DISABILITY RATING.

*****(If you checked one of the above boxes, then you do not need to have part C completed).*****

I DO NOT FALL INTO ANY OF THE ABOVE FOUR CATEGORIES, THEREFORE I HAVE PROVIDED THE MBTA WITH INFORMATION FROM MY LICENSED HEALTH CARE PROFESSIONAL (PART C).

I AGREE TO RELEASE THIS INFORMATION TO THE MBTA FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR A TRANSPORTATION ACCESS PASS. THE MBTA RESERVES THE RIGHT TO CONTACT THE LICENSED PROFESSIONAL COMPLETING THIS APPLICATION.

SIGNATURE OF APPLICANT: _____

IMPORTANT RULES AND CONDITIONS OF USE:

- Your participation in the reduced fare Transportation Access Pass (TAP) CharlieCard Program is administered in accordance with the MBTA's Privacy Policy. The policy can be found on the MBTA website (www.mbta.com).
- Your TAP CharlieCard is subject to inspection or review by MBTA personnel at any time to ensure that the authorized person is using the card.
- An unauthorized person using your TAP CharlieCard is subject to criminal/civil penalties under Chapter 161, Section 113A of the MA General Laws and/or any other applicable MA General Laws. Additionally, you may be disqualified or suspended from participating in the TAP CharlieCard program for allowing unauthorized use of your card.

PART C: HEALTH CARE CERTIFICATION.

TO BE COMPLETED BY A LICENSED/CERTIFIED HEALTH CARE PROFESSIONAL:

Please answer all applicable questions thoroughly on this page. Review and complete the "GUIDELINES FOR HEALTH CARE PROFESSIONALS" on the next page. Eligibility for this applicant will be determined based on the information you supply.

HEALTH CARE PROFESSIONAL'S NAME (PLEASE PRINT):		LICENSE NUMBER/STATE:	
BUSINESS ADDRESS:	CITY:	STATE:	ZIP:
TELEPHONE: ()	LICENSURE TITLE:		

What is applicant's disability(s)? *(Please print or type)* _____

In what way does this cause the applicant difficulty when traveling on mass transit? _____

Is this disability: **Temporary?** _____(under 6 months) _____ (over 6 months), or Permanent? _____

Does applicant have a mobility or coordination disability? Yes:_____ No:_____ If yes, explain: _____

What type of mobility device (if any) does applicant use?:_____

Does applicant's disability cause dyspnea upon exertion? Yes:_____ No: _____ if yes, explain: _____

Does the applicant suffer from a serious, long-term mental illness that includes a substantial disorder of thought, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet ordinary demands of life **and/or** as a result of serious, long-term mental illness, is the applicant unable to meet independent life support needs of food, shelter, clothing management of finances, and health care?

Yes:_____ No:_____. If yes, please describe nature and severity of impairment:_____

Is applicant able to hear signals/announcements, read signs and follow instructions in the event of an emergency?

Yes:_____ No:_____ if no, explain: _____

GUIDELINES FOR HEALTH CARE PROFESSIONALS

Please indicate below which of the categories apply to the applicant. Be sure to include any additional information we request.

<p>1. <u>NON-AMBULATORY DISABILITIES:</u> Those who require the assistance of a wheelchair.</p>	<p>2. <u>SEMI-AMBULATORY DISABILITIES:</u> Those who require the use of a walker, crutches, or leg braces.</p>
<p>3. <u>MUSCULOSKELETAL CONDITIONS</u> such as muscular dystrophy, osteogenesis imperfecta or rheumatism restrictions. <i>Please specify therapeutic grade according to ARA, and indicate which limbs are affected.</i></p>	<p>4. <u>AMPUTATION OF AN EXTREMITY.</u> <i>Please specify which limb(s) are affected.</i></p>
<p>5. <u>SEVERE EFFECTS FROM CVA (STROKE):</u> Eligible conditions include functional motor deficit affecting any two limbs or ataxia 4 months post cva.</p>	<p>6. <u>SEVERE PULMONARY CONDITIONS</u> that affect mobility. <i>If this section is applicable please attach a copy of the most recent pulmonary function tests.</i></p>
<p>7. <u>SEVERE CARDIAC CONDITIONS.</u> <i>If this section is applicable, please include functional class of impairment and therapeutic grade as defined by the N.Y. HEART ASSOCIATION.</i></p>	<p>8. <u>PERSONS REQUIRING KIDNEY DIALYSIS TREATMENT</u></p>
<p>10. <u>HEARING IMPAIRMENTS:</u> Deafness or hearing loss of 90 db or greater in the 500, 1,000, and 2,000 HZ. ranges. <i>Please specify below the degree of response in each of these ranges.</i></p>	<p>9. <u>VISION IMPAIRMENTS:</u> Those whose visual acuity in the better eye, after correction, is 20/200 or worse, or visual field is contracted ("tunnel vision").</p>
<p>12. <u>MENTAL RETARDATION.</u> <i>Please include I.Q.</i></p>	<p>11. <u>COORDINATION DISABILITIES.</u> Those persons with a functional motor deficit in any two limbs or who experience manifestations which significantly reduce mobility, coordination and/or perception.</p>
<p>14. <u>EPILEPSY(CONVULSIVE DISORDER).</u> <i>Please include severity and frequency of seizure activity despite medication.</i></p>	<p>13. <u>CEREBRAL PALSY.</u> <i>Please include extent of difficulty in motor function.</i></p>
<p>16. <u>NEUROLOGICAL DISABILITIES</u> affecting perceptual and behavioral functioning. <i>Please include nature of condition and etiology.</i></p>	<p>15. <u>AUTISM.</u> Please describe nature and severity of impairment.</p>
<p>18. <u>PROGRESSIVE ILLNESSES</u> including Acquired Immune Deficiency Syndrome and/or cancer. The disease must impact the performance of the applicant's organic system so the symptoms produced fall within one of the above categories.</p>	<p>17. <u>PSYCHIATRIC DISABILITIES.</u> This section applies to those individuals who suffer from a serious, long-term mental illness, and/or as a result of serious, long-term mental illness, the individuals are unable to meet independent life support needs of food, shelter, clothing, management of finances, and health care. <i>Please indicate description and duration of condition.</i></p>

Which of the above categories best describes this applicant's disability? _____ Please provide us with any additional information that you feel would help us to make our decision regarding eligibility:

LICENSED HEALTH CARE PROFESSIONAL: PLEASE SIGN BELOW:

I hereby claim that the above information is accurate and true to the best of my knowledge.

DATE: _____