**COMMONWEALTH OF MASSACHUSETTS**

**REDUCED FARE PROGRAM 8/2017**

 **Transportation Access Pass CharlieCard Application**

**Incomplete Applications Will Not Be Processed or Returned**

 **PART A: To Be Completed by Applicant**

**Applicant Information: (Please Print) 🞎** First time applicant **🞎** Renewal

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt. No.\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information:** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disability Information Release Authorization:**

I authorize the health care professional completing this application to release information about my disability to the Massachusetts Bay Transportation Authority (MBTA).

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Applicant Original Signature**  **Date**

**Application Submittal:** Please return the completed application to the following address.

**No Photocopies or faxes accepted.**

MBTA CharlieCard Store, Downtown Crossing Station, Chauncy Underground Concourse, 7 Chauncy St., Boston, MA 02111

**You will receive an Application Status Letter in 6 – 8 weeks**

 **with instructions how to obtain your Reduced Fare CharlieCard.**

**When visiting the CharlieCard Store, please present original documentation and valid Driver’s License or ID with an expiration date from the Registry of Motor Vehicles or Passport**.

 **PART B: TAP CharlieCard Eligibility Criteria**

**Automatically Eligible Applicants (Original Documents ONLY)**

Applicants who meet one of the criteria below are automatically eligible for a Transportation Access Pass CharlieCard. Simply complete PART A, check off the category below that applies to you and present the required documentation.

**Application may be subject to submission depending upon documentation presented**

**🞎** **Medicare Card Holder/Part A & B or One Care Card:** Please present your Red, White, and Blue Medicare Card or Commonwealth Care Alliance One Care Card at the time of visit. (**No Photocopies)**

* **Current customer of THE RIDE:** RIDE ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* **Veteran with a disability rating 70% or greater:** Present Benefits Summary Letter on Veterans Administration letterhead, specifying disability rating.

**🞎 Reduced Fare card holder from MA or Out-of-State:** Present a current reduced fare card from your state or area with an expiration date.

* **Clients of the following agencies**: Present original letter on agency letterhead, from authorized agency representative (or vendor) verifying status as current client.
	+ DMH/Department of Mental Health
	+ DDS/Department of Developmental Services
	+ MRC/Massachusetts Rehabilitation Commission

**All Other Applicants**

If you do not meet one of the above criteria, complete PART A and have your licensed health care professional complete PART C of this application.

**IMPORTANT RULES AND CONDITIONS OF USE**

* Your participation in the Transportation Access Pass CharlieCard Program is administered in accordance with the MBTA's Privacy Policy. The policy can be found at www.mbta.com.
* Your Transportation Access Pass CharlieCard is subject to inspection or review by MBTA personnel at any time to ensure use by only the authorized person.
* An unauthorized person using your Transportation Access Pass 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 Transportation Access Pass CharlieCard program for allowing unauthorized use of your card.

 **PART C: Health Care Professional Certification**

PART C must be completed by a licensed or certified health care professional, and must be received by the MBTA within 60 days of the health care professional’s signature. Please **P-R-I-N-T**.

Name of Health Care Professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Licensure Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Issued \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT PROGRAM NOTE:** The MBTA issues the Transportation Access Pass CharlieCard based on the level of difficulty applicant’s experience, and the extra planning and effort that may be required, to use public buses/trains/subway due to a physical, psychiatric, intellectual or sensory disability. The TAP CharlieCard is issued to applicants with disabilities who find it moderately/severely difficult to wait for a bus, hear announcements, read visual signs, understand and/or follow directions, board the correct train, maintain stamina, function well in crowds, walk certain distances to transfer between transit modes, etc. The TAP CharlieCard **IS NOT ISSUED** based on applicant's income level.

**1. What is the applicant's disability?**

 Use *Guideline Number(s*) from back page\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Specific Diagnosis: (**Must be completed by the Health Care Professional)**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. How does the disability cause the applicant difficulty, as described in "Important Program Note" section above, when traveling on the MBTA?**

 Please specify: **(Must be completed by the Health Care Professional)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Expected duration of disability**: Please select only **one** of the two options below:

 \_\_\_\_\_\_\_\_\_ Conditions with potential for improvement within 1 year

 \_\_\_\_\_\_\_\_\_ Conditions with no expectation of improvement

**4. I certify that the information I have provided above about this MBTA TAP CharlieCard applicant is correct to the best of my knowledge:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Original Signature of Health Care Professional** **Date**

 **Guidelines for Health Care Professionals**

**Please use the categories below to complete Part C *Health Care Professional Certification*, Item #1: "What is applicant's disability?"**

|  |  |
| --- | --- |
| **1. WHEELED MOBILITY DEVICE USERS:** Those who, due to a disability, require the use of wheeled mobility, e.g. wheelchair, scooter, etc.  | **2. SEMI-AMBULATORY DISABILITIES:** Those who, due to a disability, walk with difficulty or insecurity and may or may not use leg braces, walker, cane, crutches.  |
| **3. SEVERE MUSCULOSKELETAL CONDITIONS** such as muscular dystrophy, osteogenesis imperfecta or arthritis where functional capacity is limited in ability to perform usual self care and/or vocational and avocational activities.  | **4. AMPUTATION OF AN EXTREMITY.**  Please specify which limb(s) are affected. |
| **5. SEVERE EFFECTS FROM CVA (STROKE):** Eligible conditions include functional motor deficit affecting any two limbs or ataxia 4 months post cva. | **6. SEVERE PULMONARY CONDITIONS** (obstructions/ restrictions) that affect mobility. Those with PFT outcomes < 50% of predicted values (FEV1; FVC; %FEV1; FEF25%-75%). Dyspnea occurs during usual activities of daily living; climbing a flight of stairs or walking 100 yards; with the slightest exertion; or even at rest.  |
| **7**. **SEVERE CARDIAC CONDITIONS** that result in moderate or marked restriction in ordinary physical activity; and may cause fatigue, palpitations, dyspnea or angina pain when walking one or more level blocks, climbing a flight of ordinary stairs, or even at rest. Classifications: Functional III or IV; Therapeutic C or D.  | **8. PERSONS REQUIRING KIDNEY DIALYSIS TREATMENT** |
| **9. VISION IMPAIRMENTS:** Those who are legally blind, whose visual acuity in the better eye, after correction, is 20/200 or worse or visual field is contracted. [Applicant will be eligible for ***MBTA Blind Access CharlieCard***with a current MA Commission for the Blind Card/Certificate or other Blindness Certification]  |
| **10. HEARING-RELATED DISABILITIES:** Deafness or hearing loss of 90 db or greater in the 500, 1,000, and 2,000 HZ ranges. Please specify the degree of response in each of these ranges. | **11. COORDINATION DISABILITIES:** Those with a functional motor deficit in any two limbs or who experience manifestations that significantly reduce mobility, coordination and/or perception.  |
| **12. INTELLECTUAL DISABILITY:** Those with I.Q. more than two standard deviations below the norm.Please specify I.Q. | **13. CEREBRAL PALSY:** Please include extent of difficulty in motor function. |
| **14. EPILEPSY (CONVULSIVE DISORDER):**  Please include severity and frequency of seizure activity despite medication. | **15. AUTISM:** Please describe nature and severity of disability. |
| **16. NEUROLOGICAL DISABILITIES** affecting learning, perceptual and behavioral functioning. Please include nature of condition and etiology*.* | **17. PSYCHIATRIC DISABILITIES:** This section applies to those who have a **serious, long-term mental illness**, that:* includes a substantial disorder of thought, memory, perception, or orientation
* grossly impairs judgment, behavior, capacity to recognize reality, or
* greatly impacts ability to meet ordinary/independent life support needs of food, shelter, clothing, management of finances, and health care.

 Please indicate description and duration of condition*.* |
| **18***.* **PROGRESSIVE ILLNESSES**that impact the performance of the applicant's organic system so the symptoms produced fall within categories 1 – 17 above. Please indicate applicable categories above that best describe impact of illness on applicant's functional ability to use public transit buses, subway and trains. |

**For Internal Use Only:** Staff initials \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Approved: \_\_\_\_\_\_\_\_\_\_ Auto Renew \_\_\_\_\_\_\_\_\_\_ Denied \_\_\_\_\_\_\_\_\_\_ Incomplete \_\_\_\_\_\_\_\_\_\_