ESCAMBIA COUNTY AREA TRANSIT

Disabled Reduced Fare Application and Medical Verification Form

Thank you for your interest in Escambia County Area Transit's Disabled Reduced Fare. This program provides a reduced ECAT fare for eligible disabled customers. If your eligibility is approved, you will be required to have an identification card made verifying your eligibility. Please call **(850) 595-3228** for current identification card pricing.

- Disabled Reduced Fares are offered in accordance with the Federal Transit Administration statute 49 U.S.C. § 5307(d) & 49 C.F.R. § 609.23. Individuals with physical, developmental, or mental disabilities may apply for eligibility.
- If you have a Medicare Card, a Social Security Statement (within 90 days) verifying disabled income, or a Veteran's Affairs (VA) card accompanied with a photo I.D. – you may purchase an ECAT Reduced Fare identification card immediately.
- Your application will not be processed until ECAT has received your completed application, and a **licensed health care professional** has completed your medical verification form.
- Your identification card **must** be presented upon boarding to receive the discounted fare.

MEDICAL RELEASE

Name: _____ Phone Number: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip:_____

Licensed Health Care Professional Information

Name: _____

Phone Number: _____

Address/Organization:_____

City, State, Zip: _____

The licensed health care professional completing this form is familiar with my disability and is authorized to provide information to Escambia County Area Transit.

Applicant's Signature_____

Date_____

Applicant: Please do not write below this line

Please mail, hand deliver, or fax this form to:
Escambia County Area Transit
1515 West Fairfield Drive
Pensacola, FL 32501
Phone: (850) 595-3228

Fax: (850) 595-3222

DISABLED REDUCED FARE MEDICAL VERIFICATION FORM

Dear Licensed Health Care Professional:

The applicant, _____has requested that Escambia County Area Transit issue him/her a photo ID card that would enable him/her to ride the bus for a reduced fare. Listed below are the criteria that are used to determine if he/she meets the eligibility requirements. Would you please review and indicate by checking "Yes" or "No" at the bottom of this form if this person meets any of these requirements and return this letter to Escambia County Area Transit? **PLEASE DO NOT INDICATE THE DISABILITY THAT PERTAINS TO THIS INDIVIDUAL.**

Disability Verification

1. Non-ambulatory Disabilities: Impairments from any source which cause a temporary or permanent adverse effect in walking or standing other unassisted personal movement as found by the non-afflicted general public.

2. Mobility Disabilities: Impairments that cause individuals to walk with difficulty or insecurity including individuals using a long leg brace, a walker or crutches to achieve personal mobility.

3. Arthritis: Persons who suffer from arthritis, which causes a functional motor defect in any two, major limbs (arms and/or legs).

4. Amputation: Persons who suffer amputation of, or anatomical deformity of both hands, of one hand and one foot; or amputation of lower extremity at or above the tarsal region (one or both legs).

5. Cerebrovascular accident: (Stroke) with pseudobulbar palsy; or functional motor deficiency in any of two extremities; or ataxia affecting two extremities substained by appropriate cerebellar sign or proprioceptive loss.

6. Pulmonary Condition: Persons suffering respiratory impairment, class 3, 4, or 5.

7. Cardiac Condition: Persons suffering functional classifications of cardiac disease, class 3 and 4 and therapeutic classification, class c, d, and e.

8. Dialysis: Persons who, in order to live, must use a kidney dialysis machine.

9. Sight Disability: Those persons whose:
   A. Vision in the better eye after best correction is 20/200 or less or
   B. Visual field is constructed (commonly known as tunnel vision)
      i. To 10 degrees or less from a point of fixation; or
      ii. So the widest diameter subtends an angle no greater than 20 degrees; or
      iii. Those persons who can show proof of denial of a valid Florida driver's license, on the basis of the vision test

10. Hearing Disabilities: Those persons who:
    A. Have deafness or other hearing impairment that may make an individual susceptible to danger in public areas because the individuals is unable to communicate or hear warning signals, including those persons whose hearing loss is 70DBA or greater in the 500,1000,2000hz ranges.
    B. Can show proof of denial of Florida drivers license due to hearing loss.

11. Coordination Disabilities

12. Mental Retardation: (General guideline is an IQ which is more than two standard deviations below the norm)

13. Cerebral Palsy

14. Epilepsy: Persons who exercise grand mal seizures more than once a month in spite of prescribed treatment with:
    A. Diurnal Episodes; or
    B. Nocturnal Episodes
    C. Individuals who can show proof of denial of Florida drivers license due to epilepsy
15. Autism
16. Neurological Handicap
17. Emotionally Disturbed: To the extent of total disability and
    A. Living in board and care home or at home under supervision or independently, AND
    B. Eligible to receive state or federal financial assistance or SSI; and
    C. Participating in a state or federally funded social service agency.

EXCLUSIONS: PERSONS WHOSE SOLE INCAPACITY IS:

1. PREGNANCY
2. OBESITY
3. ILLITERACY
4. CHEMICAL DEPENDENCY (alcohol, drugs, etc.)

_____ meets requirements: ⓞ Yes ⓞ No

This section must be completed or application will be returned.

Please Print: All information in this box <u>MUST</u> be provided by treating physician or licensed health care provider

_____

Physician's / Licensed 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 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.

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