# TRPTA

**TARGHEE REGIONAL PUBLIC TRANSPORTATION AUTHORITY**

## Application for ADA Reduced Fare Fixed Route ID Card

### Instructions:

**Please read and fill out <u>all</u> pages of application as necessary.**

When form is completed, sign on Page 2, and mail or return in person to Paratransit Administrator with eligible documents. Copies will be made if necessary.

After application and all qualifying information is received, we will contact you by phone about eligibility and, if eligible, schedule a time to take your picture for your photo ID.

**Please Print:**

Name _____
First Middle Last

Address _____
Street City State Zip

Date of Birth _____E-mail_____ Phone No. _____
Area Code

I am applying for the ADA Reduced Fare Fixed Route ID Card on the following basis and am providing accompanying proof and Photo ID. **Please check all that apply:**

☐ I have a Medicare Identification Card.

☐ I have an Idaho DMV Disability Placard with current "valid through" date.

☐ I receive Supplemental Security Income [SSI] or Social Security Disability Insurance [SSDI] benefits (copy of award letter, benefit adjustment letter, benefit check)

☐ I am providing proof of current eligibility by the Veteran's Administration as having a disability of 40% or greater.

☐ I have a qualifying medical disability diagnosed by a qualified medical individual and am providing a release to contact them for further information. **See instructions on back.**

☐ I am providing a valid ADA Paratransit Card from another agency (for temporary only).

**PLEASE FILL OUT INFORMATION ON BACK AND SIGN MEDICAL RELEASE ON PAGE 3.**

## Instructions for Medical Release

To certify that you have a diagnosed disability, please provide contact information for a qualified medical individual. A qualified medical individual is a licensed:

- Physician (M.D. or D.O.)
- Optometrist
- Psychiatrist
- Advanced-Practice Professional Nurse
- Audiologist
- Physician's Assistant
- Psychologist (Ph.D.)

Medical Professional Information:

Name_____

Address_____
Street City State Zip

Phone Number_____ Fax Number_____

Type of Qualified Medical Individual_____

T.R.P.T.A. may use this information to contact the qualifying medical individual for further clarification using the attached form. Please sign the medical information release form on the next page.

**APPLICATION NOT COMPLETE UNLESS SIGNED BELOW**

Applicant's Signature_____ Date _____

**Please Return with Proof of Eligibility Documents by mail or in person to:**

**Alden Allen, Paratransit Administrator**
**T.R.P.T.A.**
**1810 W. Broadway #7**
**Idaho Falls, ID 83402**
**ada.trpta@gmail.com**

This application is available in accessible formats

For Office Use Only:
Type of Proof:

| | |
|---|---|
| □ Medicare | □ ADA |
| □SSI/SDI | □ VA |
| □DMV Placard | □ Medical |

Web Application

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## MEDICAL INFORMATION RELEASE

**I hereby authorize Targhee Regional Public Transportation Authority to contact the qualified medical individual to complete this application as necessary. I understand that any information is confidential and shall not be released without my approval or a court order. I understand that T.R.P.T.A. shall have the right and opportunity to verify my eligibility for ADA Reduced Fare. I understand that if any statements on this application form are false or inaccurate, I will lose the privileges granted by the ADA Reduced Fare ID program. I further understand that I can revoke this consent at any time by providing written notification of revocation to T.R.P.T.A.**

Applicant's Signature_____ Date _____

**THIS SECTION TO BE COMPLETED BY IDENTIFIED HEALTHCARE PROVIDER:**

1. This applicant must meet at least one of the criteria and conditions listed on the back of this form.
2. This specific Medical Eligibility Criteria Letter must be noted in space provided.

I hereby certify that _____meets the Medical Eligibility Criteria _____.
Date of Onset_____ Date of Last Visitation_____

Please Check the Appropriate Box
Yes No

☐ ☐ This disability is Temporary. Specify length of disability: _____months. A temporary disability must be expected to last at least three months, but no longer than one (1) year.

☐ ☐ This disability is permanent.

☐ ☐ This disability requires: a Personal Care Attendant ☐ Service Animal ☐ Mobility Aid ☐

Verification of Approved Health Care Provider

_____
Doctor's Full Name License No.

_____
Address City State Zip

_____
Telephone Number Fax Number

_____
Signature Date

# Medical Eligibility Criteria

## Mobility Impairments

**A.** Non-ambulatory: Requires use of a wheelchair.

**B.** Mobility-Aided: Requires use of an AFO or larger leg brace, walker, or crutches to achieve mobility.

**C.** Arthritis: Therapeutic Grade III or worse, Functional Class III or worse, Anatomical Grade III or worse.

**D.** Amputation/Deformity: Traumatic loss of muscle mass or tendons or x-ray evidence of bony or fibrous ankylosis, joint subluxation or instability of both hands, one hand and foot, or amputation at or above tarsal region.

**E.** Stroke: Causing Pseudobulbar Palsy, sustained functional motor deficit of gross/dexterous movement or gait, ataxia affecting two extremities**.**

## Physical Impairments

**F.** Respiratory: Class III or greater.

**G.** Cardiac: Vascular impairments of Functional Class III or IV and Therapeutic Class C, D or E.

**H.** Dialysis: Individuals who require kidney dialysis to live.

**I.** Neurological Impairments: As contained in Disability Evaluation Under Social Security Publication.

**J.** Chronic Progressive Debilitating Disorders: Diseases that are characterized by chronic symptoms such as fatigue, weakness, weight loss, pain and changes in mental status which interfere in daily living activities and significantly impair mobility.

- Progressive and uncontrollable malignancies
- Advanced connective tissue disease such as Lupus Eythematousus, Sclerodema, or Polyarteritis Nodosa
- Symptomatic HIV: (AIDS or ARC) in CDC defined clinical group IV, Subgroups A-E

## Visual Impairments

**K**. Legally Blind.

**L.** Visual Acuity: No better than 20/200 after correction in best eye, or visual field is contracted to 10 degrees or less from point of fixation or subtends to angle no greater than 20 degrees.

## Mental impairments

**M.** Mental/Emotional: Individual with a mental or emotional impairment listed in Diagnostic and Statistical Manual IV of the American Psychiatric Association, the severity of which meets or exceeds standards outlined in the Disability Evaluation Under Social Security Publication. Disability must have been present for at least 3 months and be expected to continue for at least 3 months past the application date.

**N.** Autism: Syndrome consisting of withdrawal, inadequate social relationships, language disturbance and monotonously repetitive motor behavior.

## Hearing Impairments

**O.** Total deafness.

**P.** Persons whose hearing loss is 70 dba or greater in the 1000 and 2000 Hz ranges.