Field Trips c/o TCC
3130 East Main Str. Suite 2a
Springfield, Ohio 45505
Or email to
gmassie@clarkcountyohio.gov

REDUCEDFARE APPLICATION FOR A PERSON WITH A DISABILITY

PART1-TO BE COMPLETED BY APPLICANT (PLEASE PRINT)

_____ _____ _____
Last Name FirstName M.I.

_____ _____ _____
Street Address Apt.# City Zip

Phone Numbers _____ _____ _____
Home Cell Email

Sex: _____ Male _____ Female

Date of Birth: _____ Height: _____ Weight: _____

I am applying for a Field Trips reduced fares because:

Check One

A. I am over 65 years old _____

Submit a scan or picture with this form. You do not need Part II filled out.

B. I have a Medicare Card _____

Submit a scan or picture with this form. You do not need Part II filled out.

C. I have a legally documented disability _____

You musthavea physician fill out Part II.

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

_____ _____
Signature of Applicant Date

Part II - To be completed by a licensed physician only

To be eligible for the Field Trips 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 Field Trips public microtransit 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.

A. 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-pulmonaryDisease

Serious loss of heart of 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.

B. Visual Disabilities

_____ _____1. LegallyBlind

Visual impairment that is bilateral and not correctable with lenses.

2. Contraction ofVisualField

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.

C. Hearing Disabilities

_____ 1. LegallyDeaf

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

D. Mental Disabilities

_____ 1. Developmentally Disabled

Mental disability that originatedbefore age 22.

_____ 2. AdultMentalRetardation

State of significant subnormalintellectual development with reduction of social competence in a person to the extent thattheperson requires care and treatment for his/her own welfare and the welfare ofothersin 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. NeurologicalDisabilities

Neurological and physical impairments not controlled by medication such as cerebral palsy or multiple sclerosis.

_____ 6. OrganicBrain 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 notsignificantlyinterferewith 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

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Date Received: _____ Approved _____ Expiration Date: _____

Denied _____ Incomplete _____ Reason: _____

Signature: _____ Date: _____