The Greater Cleveland Regional Transit Authority

The attached application must be completed by individuals who would like to participate in our disability program for regular bus and rail. This application must also be used for individuals who are recertifying their enrollment in the disability program.

To apply for eligibility in our Fixed Route Disability Fare program

1. You must fill out page 2 and 3 of the application completely. (If you are a Service Connected Veteran with this shown on your card, or if you have a valid Medicare card, you may use those instead of the application.)
2. A medical professional or social worker **must complete page 4, 5 and 6.**
3. Bring the completed application and $5.00 to 1240 West 6th Street, **along with a valid photo ID card.**
4. **All applications that are not completed correctly will not be processed. No exceptions.**

To Replace a Lost or Stolen Card

1. You must come to RTA's Main Office- 1240 West 6th Street.
2. There is a **2 week waiting period** for all lost or stolen cards.
3. There is a $5.00 replacement fee for all lost or stolen cards.
4. **A photo ID is required for replacement of your card.**
5. **No ID, No Card. NO EXCEPTIONS.**

GREATER CLEVELAND REGIONAL TRANSIT AUTHORITY
APPLICATION FOR FIXED ROUTE DISABILITY PROGRAM

ELIGIBILITY:

To qualify for the Greater Cleveland Regional Transit Authority's Fixed Route Disability Program, you must have a physical or mental impairment that is listed on the eligibility criteria list. The impairment must be verified by a health-care professional.

EXCLUSIONS:

A person whose sole incapacity is pregnancy, obesity, acute or chronic alcoholism, or drug addiction, or who have a contagious disease, is not eligible for a fixed route disability.

PART I: BACKGROUND INFORMATION OF APPLICANT
The front and back of this application must be completed for eligibility consideration. Please PRINT clearly.

Name:____
Last First M.I.

Address: ____

City: ______________________________ State:_______ Zip Code: ____________________

Phone: (Home)______________________(Work)________________________________

E- mail address____

Last 4 digits of Social Security Number: XXX-XX-__________________
Note, Last 4 digits of the Social Security Number is for tracking applications only.

Date of Birth: ____________________ Gender: Male ______ Female______

Check the appropriate box and sign below:

- ❑ **New card:** If you have not had a Fixed Route card before, check this box. Cost is $5.00. You must have your physician or licensed health care provider complete and sign Part IV. of this application.
- ❑ **Renewal card:** If your Fixed Route card is expiring, check this box. Cost is $5.00.
- ❑ **Replacement card:** If your Fixed Route card was lost or stolen, check this box. The cost of a replacement is $5 the first time, $10 the second time, and $15 the third time. Replacement of a fourth card will require a 30 day waiting period and cost $20. Continued replacement card requests will require longer waiting periods and increasing costs in $5 increments.

OFFICE USE ONLY									
Date Entered		Disability Code		Form Reviewed	Yes		No		Date
Category				Eligibility Approved	Yes		No		Date

PART II: INFORMATION ABOUT YOUR DISABILITY

I am eligible for the Fixed Route Disability Fare Program because I have a medically documented disability in performing at least one of the following transit-related functions (check the appropriate box or boxes):

- ☐ Getting on or off a standard RTA bus/rail car
- ☐ Standing in a moving RTA bus/rail car
- ☐ Reading information signs (Legal blindness of 20/200 with best possible correction (tunnel vision) or a field of vision that is less than 20 degrees in the better eye, or a reduction in eyesight of the visual field. (Hemianopia))
- ☐ Hearing directions (Average loss of 30 decibels within speech frequencies in both ears, with the best possible correction is the minimum requirement)
- ☐ Understanding information signs and/or directions of the bus/rail operator

What is/are your disability/disabilities?____

____

____

PART III: NOTARY

Application will not be accepted if this oath is omitted. You must personally appear before a notary public or other authorized official for this purpose.

I solemnly affirm that the information I have provided on this application is complete and true to the best of my knowledge and belief and that intentional deception herein may be considered as significant cause for my disqualification of the Fixed Route Disability Program. I will not loan my card to anyone. I also understand that RTA employees are authorized to confiscate my I.D. card if it is used improperly.

I understand that falsification of this application may be considered grounds for termination in the Fixed Route Disability Program. I understand that it is a criminal offense to make false statements before a notary public and I may be liable for a criminal offense if false statements are attributed to this application.

I understand that the information on this application will be kept confidential by the professionals involved in evaluating my eligibility. I understand that RTA will contact the physician or licensed health-care provider on Part IV to verify my qualifying disability. I authorize the certifying physician or licensed health- care provider to provide all information needed to RTA in determining my eligibility for the Fixed Route Disability Program. I understand that RTA may share appropriate information with coordinating non-profit or government agencies.

____
Signature of Applicant

Subscribed and duly sworn before me according to the law, by the above named applicant this ____ day of ______________________20___ in Cleveland, County of Cuyahoga and State of Ohio.

____
Signature of Officer

____
Official Title

PART IV: MEDICAL PROFESSIONAL CERTIFICATION OR AGENCY

Please PRINT: All information in this section must be completed. Only sign if you are treating the applicant for a qualifying disability.

Name:____

Address:____

City:______________________________State:_______ Zip Code:___________________________

Office Telephone Number: ____________________Facsimile Number:_________________________

License/Certification Number:________________________State:_____________________________

Please indicate Profession:

Physician _________ Social Worker________

Other, please specify: ____

The impairment or disability is considered:
Permanent ( ) Temporary ( ) Estimated Period of Disability from ______ to ______.

Please identify the following criteria that apply:_______________________________________

____

____

ELIGIBILITY CRITERIA:

To qualify for the Fixed Route Disability Program, you must have a physical or mental impairment that is listed on the eligibility criteria list and is verified by a health-care professional.

1. **NON-AMBULATORY**
   Impairments that, regardless of cause, make the use of a wheelchair necessary.

2. **MOBILITY DISORDERS**
   Impairments that require individuals to use functional limb orthotic or longer leg brace, a walker or crutches to achieve mobility.

3. **AMPUTATION**
   Individuals with amputation of, or anatomical deformity of, or traumatic loss of muscle mass or tendons, or X-ray evidence of bony or fibrous ankylosis at an unfavorable angle, joint subluxation or instability of:

   (a) Both hands;
   (b) One hand and one foot; or
   (c) Amputation of lower extremity at or above the tarsal region.

4. **FUNCTION MOTOR DEFICIT**
   Individuals with paralysis in coordination, or function motor deficit in any two limbs due to brain, spinal, or peripheral nerve injury, including paraplegia, quadriplegia, and hemiplegia.

5. MUSCULO-SKELETAL

Individuals with musculo-skeletal impairments and instability such as muscular dystrophy, multiple sclerosis, osteogenesis imperfecta, or severe arthritis as specified below:

American College of Rheumatology criteria to be used for the determination of arthritic disability. Therapeutic Grade III or worse, Functional Class III or worse, and Anatomical Grade III or worse are evidence of arthritic disability.

A diagnosis of Grade III arthritis entails corroborative testing confirming that one or more of the following exists:

(a) Positive serologic test for rheumatoid factor;
(b) Antinuclear antibodies;
(c) Elevated sedimentation rate, or
(d) Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule.

Certifying professional must provide information as to what test(s) were conducted to arrive at the diagnosis of Grade III arthritis.

6. CONVULSION DISORDER

Individuals who have epilepsy, convulsions, or seizures involving impairment of consciousness, which occurs more frequently than once a month, despite prescribed treatment.

7. PULMONARY

Individuals with a respiratory impairment, Class 3 or greater, as defined by The Journal of the American Medical Association Guides to the Evaluation of Permanent Impairment, The Respiratory System, 11/22/76.

8. CARDIAC

Individuals with cardiovascular impairments of functional class III or IV and therapeutic classification. Classes C, D or E as defined by Diseases of the Heart and Blood Vessels – Nomenclature and Criteria for Diagnosis, 6th Edition, Boston, Little, Brown and Company by the New York Heart Association.

Functional Classification:

Class III – Individuals with cardiac disease resulting in marked limitation of physical activity. Less than ordinary physical activity causes fatigue, palpitation, dyspnea or original pain.

Class IV – Individuals with cardiac disease resulting in inability to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency or of the original syndrome may be present, even at rest. If any physical activity is undertaken, discomfort is increased.

Therapeutic Classification:

Class C – Individuals with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts must be discontinued.
Class C – Individuals with cardiac disease whose ordinary physical activity is markedly restricted.
Class E – Individuals with cardiac disease who should be at complete rest in a bed or chair.

9. DIALYSIS

Individuals who must use a kidney dialysis machine to live.

10. HEARING DISABILITIES

Deafness or hearing loss that makes an individual unable to hear warning signals. Persons whose hearing loss is 70 dba or greater in the 500, 1,000 and 2,000 Hz. Ranges.

11. SIGHT DISABILITIES

Individuals whose visual acuity in the better eye, after best correction, is 20/200 or less; or those individuals whose visual field is contracted to 10 degrees or less from a point of fixation or subtends to an angle no greater than 20 degrees.

12. INFANTILE AUTISM

Individuals with a syndrome described as consisting of withdrawal, inadequate social relationships, language disturbance and monotonously repetitive motor behavior. Many children with autism may also be seriously impaired in general intellectual functioning.

13. MENTAL RETARDATION

Individuals with mental retardation resulting from an impairment in adaptive behavior, with an IQ two standard deviations or more below the norm, or 72.

14. MENTAL DISORDERS

Individuals with a mental or emotional impairment listed in the Diagnostic and Statistical Manual IV of the American Psychiatric Association. The disability must have a minimum duration of three months.

15. NEUROLOGICAL IMPAIRMENTS

Individuals with a neurological disorder due to brain dysfunction or damage to the central nervous system, including cerebral palsy, resulting in aberration of motor functions; or due to brain dysfunction or damage, which impairs cognitive functioning.

16. CHRONIC PROGRESSIVE DEBILITATING DISRODERS

Individuals who experience chronic and progressive debilitating diseases that are characterized by constituting symptoms such as fatigue, weakness, weight loss, pain and changes in mental status that, taken together, interfere in the activities of daily living and significantly impair mobility. Following are examples of such disorders:

a. Progressive and uncontrollable malignancies (i.e., terminal malignancies being treated with aggressive radiation or chemotherapy);
b. Advanced connective tissue diseases (i.e., advanced stage of disseminated lupus erythematosus, scleroderma, or polyarteritis nodosa); and Symptomatic HIV infection (i.e., AIDS or ARC in CDC-defined Clinical Group IV, Subgroups A-E).

17. OTHER DISABILITY: Any other incapacity or temporary or permanent disability which would significantly affect the applicant's ability to effectively use mass transportation service or a mass transportation facility without special facilities, planning or design.

Please specify:

____

____

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 or disabilities indicated above. I understand that false certification may be reported to the licensing jurisdiction under the State of Ohio or appropriate code for state of license/ certification.

Signature______________________________ **Date**______________________