CAPE COD REGIONAL TRANSIT AUTHORITY
REDUCED FARE PROGRAM
Transportation Access Pass GoCard 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 Cape Cod Regional Transit Authority (CCRTA).

_____ _____

Applicant Original Signature **Date**

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

Email or Faxed applications accepted.

CCRTA, 215 Iyannough Rd, PO Box 1988, Hyannis, MA 02601

You will receive an Application Status Letter within 21 days with instructions how to obtain your Reduced Fare GoCard.

PART B: TAP GoCard Eligibility Criteria

Automatically Eligible Applicants (Original Documents ONLY)

Applicants who meet one of the criteria below are automatically eligible for a Transportation Access Pass GoCard. 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)**
- ☐ **Veteran with a disability rating 70% or greater:** Present original Rating Decision Letter on Veterans Administration letterhead, signed by Veterans Services personnel, 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.
- ☐ **Client of DMH/Department of Mental Health** (including DMH vendors): Present original letter on agency letterhead, from authorized DMH representative (or vendor) verifying status as current client.
- ☐ **Client of DDS/Department of Developmental Services:** Present original letter on agency letterhead, from authorized DDS representative verifying status as current client.

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

- An unauthorized person using your Transportation Access Pass GoCard 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 GoCard 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 CCRTA within 60 days of the health care professional's signature. Please **print**.

Name of Health Care Professional _____

Licensure Title _____Specialty_____

License Number _____ State Issued _____

Business Address _____

City _____State _____ Zip _____Phone _____

IMPORTANT PROGRAM NOTE: The CCRTA issues the Transportation Access Pass GoCard based on the level of difficulty, applicant's experience, and the extra planning and effort that may be required, to use public transportations due to a physical, psychiatric, intellectual or sensory disability. The TAP GoCard 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 bus, maintain stamina, function well in crowds, walk certain distances to transfer between transit modes, etc. The TAP GoCard **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 CCRTA?

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 GoCard 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 GoCard*** 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 _____