JANESVILLE TRANSIT SYSTEM DISABLED ID CARD APPLICATION

Dear Applicant:

Thank you for your interest in obtaining a Janesville Transit System Disabled ID card. This program offers a discounted fixed-route bus fare to qualified individuals. There are two categories used to determine eligibility:

1) Individual is currently covered under **Medicare** (Medicaid is ***not*** applicable);
2) Individual must have a qualifying physical or mental impairment (see back of application for details).

The application process:

- Complete and sign the front of the application.
- Have your **treating** physician or a licensed health care provider **(WI Medical License)** complete and sign the back of the application.
- Bring your completed application to:

  Transit Services Center
  101 Black Bridge Road
  between the hours of 8:30 am and 4:30 pm, Monday through Friday to receive your Disabled ID card.

  or

  Clerk-Treasurer's Office–City Hall
  18 N. Jackson Street
  between the hours of 8:00 am and 4:00 pm, Monday through Friday to receive your Disabled ID card.

Please bring a photo ID with you (i.e., driver's license, state ID, etc.)

Please note: The following will negate the application:

- Inaccurate or incomplete information on the application;
- Lack of medical verification from either **treating** physician or licensed health care provider **(WI Medical License);** or
- Failure to provide photo identification.

There is no cost to the applicant for the initial Disabled ID card, however ***if the card is lost or stolen, a replacement card will be issued at a cost of $3.00***. Janesville Transit System Disabled ID Cards are to be used ***exclusively*** by the individual named on the card. *Allowing others to use it is prohibited, and will result in the immediate loss of eligibility.*

Any questions or concerns regarding the Disabled ID Card Program, please call the Janesville Transit System at 608/755-3150.

JANESVILLE TRANSIT SYSTEM DISABLED ID CARD PROGRAM

For Office Use Only

Date Card Issued: _____ Date Card Renewed: _____ Expiration Date: _____

Comments:: _____ Staff Initials: _____

FRONT AND BACK OF APPLICATION MUST BE COMPLETED TO PROCESS

_____
Last Name First Name Middle Initial

_____
Street Address Apt. #/Lot #

_____
City State ZIP Code Area Code & Phone Number

_____/_____/_____
Month Date Year of Birth

Check the appropriate box and sign below:

- ☐ I am currently covered under Medicare (bring Medicare card with you).
- ☐ I have a physical or mental impairment, which meets the FTA definition (609.3) of a person with a disability, as listed below.

"Handicapped persons means those individuals who, by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected".

Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". Major life activities include, but are not limited to caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning, and work.

I certify that, to the best of my knowledge, the information given on this application is true and accurate. I understand that JTS will rely upon this information when determining eligibility for the Disabled ID Card Program. I understand that providing false or misleading information will result in my eligibility being revoked. Allowing individuals, other than myself, to utilize this card will also result in revocation.

I hereby authorize the release, either verbally or in writing, of any disability-related medical information to JTS. I understand that this information may be used in conjunction with this application when determining my eligibility for the Disabled ID Card Program thru JTS, and will not be released without my written authorization.

Applicant's Signature: _____ Date: _____

Applicant's Name:

Last _____

First

APPLICANT'S PRINTED NAME: _____

THIS PAGE <u>MUST</u> BE COMPLETED BY TREATING PHYSICIAN OR LICENSED HEALTH CARE PROVIDER (WI MEDICAL LICENSE)

To qualify for a JTS Disabled ID Card, your patient (listed above) must have a physical or mental impairment that falls within the eligibility criteria listed below. Certain conditions do not qualify, i.e. pregnancy, obesity, drug/ alcohol addiction, controlled epilepsy.

Please check all that apply.

A. NON-AMBULATORY:

☐ 1. Impairment which requires individual to use a wheelchair or similar mobility device.

B. SEMI-AMBULATORY:

☐ 1. **Arthritis**–American Rheumatism Association may be used as a guideline for the determination of disability; Therapeutic Grade III, Functional Class III, Anatomical State III, or worse is evidence of arthritic disability.

☐ 2. **Loss of Extremities**–Anatomical deformity of or amputation of hand(s) and/or feet, or loss of major function.

☐ 3. **Cerebrovascular Accident**–Ongoing debilitating effects following occurrence of CVA, or effects of Cerebral Palsy.

☐ 4. **Cardio-pulmonary**–serious loss of heart or lung reserves as shown by X-ray, EKG, or other tests and in spite of medical treatment, there is breathlessness, pain, or fatigue.

☐ 5. **Dialysis**–individual who must use a kidney dialysis machine to sustain life.

☐ 6. **Other** _____
(Diagnosis)
How does this affect mobility? _____
_____

C. HEARING IMPAIRMENT:

☐ 1. Legally Deaf–Hearing impairment that is bilateral and not correctable by hearing aid.

D. VISUAL IMPAIRMENT:

☐ 1. **Legally Blind**–Visual Impairment that is bilateral and not correctable with lenses.

☐ 2. **Contraction of Visual Field**–Persons whose widest diameter of visual field subtends an angular distance of 20 degrees, or less than 10 degrees from point of fixation.

☐ 3. **Low Vision**–An individual has low vision, and whose visual acuity is in the range of 20/70 to 20/200 with best correction.

E. COGNITIVE IMPAIRMENT:

☐ 1. **Developmentally Disabled**–Cognitive disability that originates before age 18.

☐ 2. **Adult Intellectual Disability**

☐ 3. **Autism**–Monotonously repetitive motor behavior with severe withdrawal, inappropriate response to stimuli, or very inadequate social relationships.

☐ 4. **Schizophrenia**

☐ 5. **Organic Brain Syndrome/Bi-Polar**–Cognitive disturbance that requires boarding or home care, funded work activity or workshop.

F. NEUROLOGICAL DISABILITIES:

☐ 1. **Cerebral Palsy**–Impairment not controlled with medication.

☐ 2. **Multiple Sclerosis**–Impairment not controlled with medication.

☐ 3. **Epilepsy**–Grand Mal or Psychomotor; Persons who are seizure-free for period of six months do not qualify.

_____ Applicant's Impairment ***DOES NOT MEET*** any of the functional limitations listed above. Therefore, I cannot certify that the applicant's impairment meets the eligibility criteria for receiving a JTS Disabled ID Card.

Please Print or Type: All Information in this box MUST be provided by treating physician or licensed health care provider (WI Med Lic).

_____
Physician's/Health Care Provider's Name — State License Number (Required)

_____
Office Address — City — State — ZIP

_____
Area Code + Phone Number — Area Code + FAX Number

I certify that the applicant listed above 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.

_____
Authorized Signature — Date