**The Metro**
**Kansas City Area Transportation Authority**
1200 E.18th St.
Kansas City, MO 64108
(816) 221-0660

# Persons with Disabilities 2012 - 2015

## Reduced Farecard Application

**Please print legibly**

Last Name | First Name | Middle Initial

Number | Street Address | Apt. #

City | State | Zip Code

Area Code | Phone Number | Male | Female | Date of Birth: Month | Day | Year | Social Security No. XXX XX (Last four digits)

**Check the appropriate box and sign below:**

☐ **First Card.** If you have not had a Persons with Disabilities Reduced Farecard before, check this box. Complete the information above and enclose **$1 cash or money order. You must have your physician or other qualified certifying agent complete and sign the back side of this application, or enclose a copy of your Medicare Card, except for replacements. No checks accepted.**

☐ **Renewal Card.** If your farecard expires on **October 31, 2012**, check this box. Complete the information above and **enclose $1 cash or money order. No checks accepted. Send cash or money order.**

☐ **Replacement Card.** If you have lost your farecard, or if your card was stolen, check this box. A replacement card costs $5 the first time, $10 the second time or $15 the third time. Additional replacements after the fourth card will be at the discretion of the issuing agent. **Certification is not required for replacement cards.** Enclose correct fee with application. **Send cash or money order. No checks accepted.**

**No Reduced Farecards will be issued over the counter.**

I understand that my Persons with Disabilities Reduced Farecard is **not transferable to other persons** and that The Metro reserves the right to determine qualifications for issuing cards in accordance with the terms and conditions stated on the reverse side of this application. This card will be valid from November 1, 2012, to October 31, 2015.

Signature _____ Date _____

**Return this completed application and the correct fee in cash or money order to the Kansas City Area Transportation Authority. No checks accepted.**

**If you are applying for your first reduced farecard, the back of this form must be completed and signed by your physician or other certifying agent, OR you may mail a copy of your Medicare Card with your application. (State Medicaid does not qualify.)**

**Medicare Card Holders** may also ride The Metro for half-fare, and will need to present their Medicare Card when using a Monthly Pass or paying a cash fare.

**For Office Use Only**

Card No. | Sticker No. | Receipt No. | Issue Date | Amount Paid | Issuer

**Revocation**

Incident No. | Reasons: _____

Additional Notes _____

## For Physician or Certifying Agency

**To qualify for The Metro's Persons with Disabilities Program, your client/patient must have a physical or mental condition that falls within the medical eligibility criteria listed below. Check all that apply.**

**Is this disability permanent?** ☐ Yes ☐ No

**Has condition existed for at least 90 days?** ☐ Yes ☐ No

### A. Non-Ambulatory Disabilities

☐ 1. Impairments which require the individual to use a wheelchair.

### B. Semi-Ambulatory Physical Disabilities

☐ **1. Restricted mobility.** Disabilities requiring the permanent use of a cane, crutches, long leg brace or other orthopedic appliances to assist an individual in moving about.

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

☐ **3. Loss of extremities.** Anatomical deformity of or amputation of both hands, one hand and one foot, or loss of major function.

☐ **4. Cerebrovascular accident.** Ongoing debilitating effects following occurrence of cerebrovascular accident, or Cerebral Palsy.

☐ **5. Cardio-pulmonary disease.** 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.

☐ **6. Dialysis.** Individual who must use a kidney dialysis machine in order to live.

☐ **7. Acquired Immune Deficiency Syndrome** (AIDS)/HIV+.

☐ **8. Other.** Please specify:_____

_____

_____

_____

### C. Visual Disabilities

☐ **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; or whose visual field efficiency is 20 degrees or less.

### D. Hearing Disabilities

☐ **1. Legally deaf.** Hearing impairment that is bilateral and **not** correctable with hearing aid.

### E. Mental Disabilities

☐ **1. Developmentally disabled.** Mental disability that originates before age 18.

☐ **2. Adult mental retardation.**

☐ **3. Epilepsy.** Grand mal or Psychomotor. Persons 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. Neurological disabilities.** Neurological and physical impairments not controlled by medication (i.e., cerebral palsy or multiple sclerosis).

☐ **6. Organic brain syndrome/emotionally disturbed. or Bi-Polar.** Mental disturbances that require boarding or home care, funded work activity or workshop.

☐ **7. Schizophrenia**

### F. Disability Benefit Recipient

☐ **1. Medicare Cardholder.** (Please send a **copy** of your Medicare Card. **State Medicaid recipients do not qualify.**)

☐ **2. Disabled veteran** certified at 50 percent or greater.

**The Metro reserves the right to confiscate a reduced farecard that has been used improperly.** Reduced farecards should not be loaned or borrowed. **A confiscated card will not be returned or replaced.** The individual may reapply after the program expiration date. This application is the property of the Metro

**Please Print** Physician's Name or Certifying Agency Agency Code No.

Address

Area Code Phone No.

Physician's State License No. Required

Due to the disability indicated above, I hereby certify that the applicant is disabled as defined by the above criteria, and to the best of my knowledge the above information is true and correct.

Authorized Signature Date