## RideKC

**Kansas City Area Transportation Authority** 

1200 E. 18th St. Kansas City, MO 64108 816-221-0660

## **Persons with Disabilities**

Reduced Farecard Application Expires: 3 years from Issue Date

Reduced Farecard Application					
Please print legibly					
Last Name First Name Middle Initial					
Street Address Apt. #					
City State Zip					
Phone Number  Male Female Month Day Year Social Security No. Check one Date of Birth  (Last four digits)					
Email (optional)					
Preferred method of contact:  □ Email □ Text Message □ Mail					
For Office Use Only					
Card No. Sticker No. Receipt No. Issue Date Amount Paid Issuer					
Revocation  Incident No.					
Additional Notes					

Cł	neck the appropriate box and sign below:		
	First Card. If you have not had a Persons with Disabilities Reduced before, check this box. Complete the information above and enclose money order. You must have your physician or other qualifying agent complete and sign the Physician Form or enclose a copy of Medicare Card, except for replacements. No checks accepted.	\$1 cash or certifying	
	Renewal Card. If your farecard is expiring this year check this box. Confirmation above and enclose \$1 cash or money order. No check Send cash or money order.	•	
	Replacement Card. If you have lost your farecard, or if your card was this box. A replacement card costs \$5 the first time, \$10 the second to third time. Additional replacements after the fourth card will be at the the issuing agent. Certification is not required for replacement card correct fee with application. Send cash or money order. No checks	me or \$15 the discretion of rds. Enclose	
No Reduced Farecards will be issued over the counter.  I understand that my Persons with Disabilities Reduced Farecard is <b>not transferable to other persons</b> and The Metro reserves the right to determine qualifications for issuing cards in accordance with the terms and conditions state on the Physician Form. This card is valid for three years from Issue 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 Physician 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 31-Day Pass or paying a cash fare.

## **Ride**KC

1200 E. 18th St. Kansas City, MO 64108

## **Physician Form**

Reduced Farecard Application for Persons with Disabilities (To be completed by a Physician or Certifying Agency)

To qualify for KCATA's Persons with Disabilities Proclient/patient must have a physical or mental condition within the medical eligibility criteria listed below. Che	n that falls	<ul> <li>C. Visual Disabilities</li> <li>1. Legally blind. Visual impairment that is bilateral and not correctable with lenses.</li> </ul>		
that apply.  Is this disability permanent?   Yes  If no, how long?   Yes	□ No	☐ 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.		
Has condition existed for at least 90 days? ☐ Yes  A. Non-Ambulatory Disabilities	☐ Yes ☐ No	<ul> <li>D. Hearing Disabilities</li> <li>☐ Legally deaf. Hearing impairment that is bilateral and</li> </ul>		
<ul> <li>Impairments which require the individual to use a Wheelchair.</li> <li>B. Semi-Ambulatory Physical Disabilities</li> <li>1. Restricted mobility. Disabilities requiring the puse of a cane, crutches, long leg brace or other orthappliances to assist an individual in moving about.</li> </ul>	permanent hopedic	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.		
☐ 2. Arthritis. American Rheumatism Association criteria may be used as a guideline for the determinanthritic disability; Therapeutic Grade III, Function	nation of			
Class III, Anatomical State III or worse is evidenc arthritic disability.		☐ <b>4. Autism</b> . Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli and very inadequate social relationships.		
☐ 3. Loss of extremities. Anatomical deformity of o amputation of both hands, one hand and one foot, major function.		☐ 5. Neurological disabilities. Neurological and physical impairments not controlled by medication (i.e., cerebral palsy or multiple sclerosis).		
<b>4. Cerebrovascular accident.</b> Ongoing debilitating effects following occurrence of cerebrovascular accident, or Cerebral Palsy.		☐ 6. Organic brain syndrome/emotionally disturbed, or bipolar. Mental disturbances that require boarding or home care, funded work activity or workshop.		
□ <b>5. Cardio-pulmonary disease.</b> Serious loss of hear reserves as shown by X-ray, EKG or other tests an of medical treatment, there is breathlessness, pain	nd in spite	☐ 7. Schizophrenia		
☐ <b>6. Dialysis.</b> Individual who must use a kidney dial machine in order to live.	C	<ul> <li>F. Disability Benefit Recipient</li> <li>☐ 1. Medicare Cardholder. (Please send a copy of your Medicare Card. State Medicaid recipients do not qualify.)</li> </ul>		
☐ 7. Acquired Immune Deficiency Syndrome (AII	OS)/HIV+.	☐ 2. Disabled veteran certified at 50 percent or greater.		
8. Other. Please specify:		KCATA 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 KCATA.		
Please Print Physician's Name or C	Certifying Age	ncy Agency Code Number		
Address				
Area Code		Physician's State License No. Required		
Due to the disability indicated above, I hereby certify knowledge the above information is true and correct.	that the appli	cant is disabled as defined by the above criteria and best of my		