

Part II - To be completed by a licensed physician only

To be eligible for the Field Trips reduced fare program, your patient/client must have a physical or mental condition that falls within the medical criteria listed below. If you confirm that the patient/client is physically or developmentally disabled, that person will be eligible for reduced fares on Field Trips public microtransit service. Persons will not be eligible for reduced fares if their sole capacity is pregnancy, obesity, and acute or chronic condition due to drugs, alcohol, or any contagious disease. All information provided will be held confidential. Application must be completely filled out. If any section is not complete the application will be determined incomplete and will not be processed.

A. Physical Disabilities

- _____ 1. **Non-Ambulatory Disabled**
Disability that will not allow that person to walk, even with the assistance of devices, but with or without the assistance of a personal care attendant (PCA), has the personal mobility and independence in a wheelchair that use of appropriate public transportation services is a reasonable expectation.
- _____ 2. **Semi-Ambulatory Disabled**
Disability that will not allow that person to walk without the assistance of walkers, crutches, canes, braces, artificial legs, or other such adaptive device, and for whom use of appropriate public transportation services is a reasonable expectation.
- _____ 3. **Loss of Extremities**
Anatomical deformity, amputation of both hands, one hand and one foot, or loss of major function.
- _____ 4. **Cerebrovascular Accident**
Ongoing debilitating effect which follows an occurrence of a cerebrovascular accident.
- _____ 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.

B. Visual Disabilities

- _____ 1. **Legally Blind**
Visual impairment that is bilateral and not correctable with lenses.
- _____ 2. **Contraction of Visual Field**
Person whose widest diameter of 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.

C. Hearing Disabilities

- _____ 1. **Legally Deaf**
Hearing impairment that is bilateral and not correctable with a hearing aid.

D. Mental Disabilities

- _____ 1. **Developmentally Disabled**
Mental disability that originated before age 22.
- _____ 2. **Adult Mental Retardation**
State of significant subnormal intellectual development with reduction of social competence in a person to the extent that the person requires care and treatment for his/her own welfare and the welfare of others in the community.
- _____ 3. **Epilepsy**
Grand Mal or Psychomotor. People 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 such as cerebral palsy or multiple sclerosis.
- _____ 6. **Organic Brain Syndrome/Emotionally Disturbed**
Chronic illness/disturbance that requires boarding or care home, funded work activity or workshop. **MUST CHECK ONE OF THE FOLLOWING WHICH BEST DESCRIBES PATIENT.**

_____ High: exhibits symptoms of severe mental illness that does not significantly interfere with daily functioning

_____ Low: exhibits symptoms of severe mental illness with such severity that daily functioning is frequent and requires intense community based services which includes community psychiatric support and treatment providers, pharmacological management, psychiatrist assessment, individual therapy and group therapy.

Is the disability permanent? Yes _____ No _____

If temporary, please list estimated number of months of temporary disability: _____

I hereby certify that the applicant, _____ is disabled as defined by the preceding criteria and that the information contained on this form is true.

Physician Signature

Date

Physicians Name

Telephone

Address: _____

Licensing Identification #

FOR OFFICE USE ONLY

Date Received: _____ Approved _____ Expiration Date: _____

Denied _____ Incomplete _____ Reason: _____

Signature: _____ Date: _____