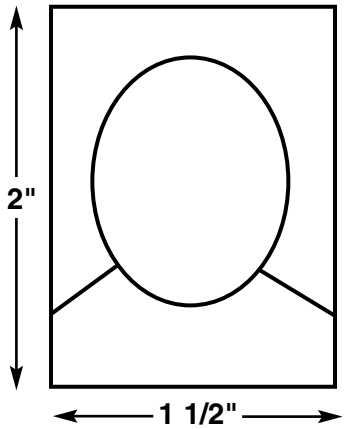
Application for MTA Reduced-Fare MetroCard for People with Disabilities

Information

Type or print in ink.



Last Name | First Name | M.I.

Street Address | Apt. No.

City | State | Zip Code

Home Telephone | Birth Date | Male | Female

Social Security Number (optional) | Code

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Mail Completed Application to:

Metropolitan Transportation Authority
Attention: Reduced-Fare Program
130 Livingston Street
Brooklyn, New York 11201-9625

For further information or additional copies of this Application or the Application for Senior Citizens, call: 718-330-1234

If you are deaf or hard of hearing, use the free 711 relay or your preferred relay service provider to contact us. Or visit **mta.info**

Allow two to eight weeks for processing.

For Office Use Only

Disk #

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Examiner's Signature

Information For All Applicants

The Metropolitan Transportation Authority's (MTA) Reduced-Fare MetroCard Program for People with Disabilities provides reduced-fare transportation for persons with the following disabilities:

- receiving Medicare benefits for any reason other than age*
- serious mental illness (SMI) and receiving Supplemental Security Income (SSI) benefits
- blindness
- hearing impairment
- ambulatory disability
- loss of both hands
- mental retardation and/or other organic mental capacity impairment

If you do not have one of these disabilities, you are not eligible for the Reduced-Fare MetroCard Program. Read the entire form carefully before you apply.

All applicants must sign the affirmation in Section 1 and have the statement and signature confirmed by a notary public.

All applicants must supply at their own expense one 2" x 1 1/2" photograph (passport type) with this application. Print your name on the back of your photograph and attach it where indicated on the front page of this application.

Each applicant must complete the section that applies to their eligibility category. If the Certification Section applies to your disability, you must have a physician or other licensed health care provider ("Certifier") complete the Certification (Section 5). You are responsible for any fee that your Certifier may charge you.

The MTA may ask for additional proof of disability and may accept or reject documentation you offer in place of the Certification. In its discretion, the MTA may waive application requirement(s) on a case-by-case basis. The MTA may require that the applicant be examined by its own physician at MTA's own expense.

***If you receive Medicare benefits based on age 65 years or older, use the Application for Senior Citizens.**

Conditions of Use

If the MTA determines that you are eligible for reduced-fare transportation, you will receive a Reduced-Fare MetroCard. You are certified for the Reduced-Fare MetroCard for four years from the date it is issued. (The temporary card can be used up to one year.) The card itself expires on the date printed in the upper-left corner of the card and will be renewed automatically.

The Reduced-Fare MetroCard is valid only if you are disabled as stated in your application. The Reduced-Fare MetroCard can be used only by the person to whom it is issued and only in accordance with the program guidelines.

If at any time you are no longer disabled as described, your eligibility for the Reduced-Fare MetroCard Program automatically ceases; you are no longer permitted to use the Reduced-Fare MetroCard, and you must return the card to the MTA.

Any violation of these Conditions of Use may result in a permanent revocation of your eligibility for the Reduced Fare Program.

Information for All Personal Representatives

If the application is completed by a personal representative of the applicant for reduced fare, the personal representative must complete the following:

Print Name of Personal Representative:

Address:

Tel. No.(s):

Relationship to Applicant:(e.g., parent, guardian, attorney, friend, etc.)

Section 1

Disability Affirmation

Must be completed by all applicants and notarized

(See Notary Section below)

I have read and understand all the program information, instructions, and conditions of use contained in this application. I affirm under penalty of perjury that all statements made by me on this application and to any Certifier (physician or other licensed professional) who is named in this application, including all statements, if any, concerning my disabilities, are true and complete. I understand that the MTA will rely on the statements made by me and by any Certifier named in this application to determine my eligibility for the Reduced-Fare Program, that all such statements may be subject to investigation and verification, and that a material misstatement or fraud will disqualify me for reduced-fare privileges. I understand that the MTA may discontinue or change its Reduced-Fare Program without notice. If the MTA determines that I have not followed the Reduced-Fare Program Conditions of Use, I understand that my Reduced-Fare MetroCard will be cancelled, and I will not be eligible to reapply for the Reduced-Fare Program. I understand that it is a crime to allow anyone else to use my Reduced-Fare MetroCard or for me to continue to use the card if I am no longer disabled as defined by the Reduced-Fare Program.

Signature of Applicant or Personal Representative named above: Date:

Notary Public

Must be completed for all applicants, except when applying in person, with photo ID

State of _____)

) ss:

County of _____)

On this _____ day of _____20__ before me appeared

to me known and known to me to be [check the one that applies]

- ☐ the person who is described in and executed the foregoing instrument
- ☐ the personal representative of the applicant named above and who executed the foregoing instrument on behalf of the applicant

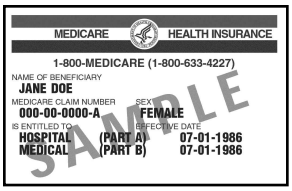
and (s)he duly acknowledged to me that (s)he executed the same and that the statements therein are true.

Signature and stamp of officer: NOTARY PUBLIC

SECTION 2

To be completed only by applicants with Medicare

☐ I am a recipient of Medicare. I have completed Section 1. Attached to this application is my photograph and a copy of my Medicare Card.



(Check the box and submit the required information)

If you receive Medicare benefits based on age 65 years or older, use the application for Senior Citizens.

SECTION 3

To be completed only by persons with SSI whose disability is serious mental illness (SMI)

Read, check the box, provide the information requested, and sign and date where indicated

☐ I currently receive Supplemental Security Income (SSI) benefits from the United States Social Security Administration (SSA) and have a serious mental illness. I understand that I am eligible to receive the MTA Reduced-Fare MetroCard only while I am receiving SSI. In the event that my SSI eligibility status changes, I agree to immediately notify MTA.

I authorize the release to MTA and its authorized designee of any records or information maintained by the SSA in its SSI Record system relevant to a determination that I am eligible to receive SSI due to a serious mental illness. This authorization is effective as follows: (1) for so long as the MTA is reviewing my application for benefits under the MTA Reduced-Fare Program; and/or (2) to determine my continued eligibility for SSI during the four-year period commencing on the date the Reduced-Fare MetroCard is issued.

I understand that, if SSA cannot confirm that my records indicate that I receive SSI and have a serious mental illness, MTA will notify me and require that I submit a certification confirming my disability from a psychiatrist or other licensed mental health care provider (Certifier), and that a determination of my eligibility for Reduced Fare will be delayed until the Certification is submitted to and reviewed by MTA. In addition, MTA may contact my health care provider directly, as follows:

Health Care Provider Name: _____

Address: _____

Tel. No.: _____

Signature of Applicant or Personal Representative _____ Date: _____

Applicant's Social Security Number: | | | | – | | | – | | | | | – | |

(Required for SSI Verification) Social Security Number Code

SECTION 4A

To be completed by all applicants not covered by section 2 or 3

My application for reduced fare is based on one or more of the following disabilities (check all that apply):

- ☐ blindness — If your eligibility is based on "Blindness" as defined in the Physician's Section and you are registered with the New York State Commission for the Blind and Visually Handicapped, you DO NOT need to have a physician complete Section 5. However you must submit a copy of your N.Y.S.C.B.V.H. Registration.
- ☐ hearing impairment
- ☐ ambulatory disability
- ☐ loss of both hands
- ☐ mental retardation or other mental capacity impairment
- ☐ I have completed and signed the Authorization to Disclose My Health Information (attached to this application) for release/disclosure of information by my Certifier. A copy has been provided to my certifier.

SECTION 4B

Complete the following if applicable:

☐ I use a service animal to travel. If checked, indicate the type of service animal (e.g., guide dog)

_____

☐ My service animal provides the following assistance.

_____

☐ My certifier has completed the Certification in Section 5.

SECTION 5

Only for applicants who are eligible under section 4A or 4B

To be completed by a physician or other appropriate licensed Health Care Provider ("Certifier")

CERTIFICATION

Type or print in ink and sign on page 6

Physician/Certifier:

Name (Last) (First) (M.I.)

Office Address Suite No.

City State Zip

Best time to call

Telephone ( )

State Professional License No.

I have examined the applicant (fully identified in the Applicant's Section of this application) and signed the back of his/her photograph and attached it to this application. It is my professional opinion that he/she is a "disabled person" within the meaning of the term set forth in this document, as follows:

Check all that apply:

☐ **Blindness** – There is central visual acuity of 20/200 or less in both eyes with the use of correcting lenses. Each eye which, accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle of greater than 20 degrees, shall be considered as having central visual acuity of 20/200 or less.

Diagnosis:

SECTION 5
(continued)

☐ **Hearing Impairment** – With hearing aids, hearing in each ear is NOT restored to one of the following minimum levels:

- ☐ Average hearing threshold sensitivity for air conduction of 90 decibels or greater, and for bone conduction to corresponding maximum levels, determined by the simple average of hearing threshold levels at 500, 1,000 and 2,000 HZ; or
- ☐ Speech discrimination scores of 40% or less in each ear.

Diagnosis:

☐ **Ambulatory Disability/Disorder of Gait**
From whatever cause, the applicant is unable to move about without a walker, wheelchair, wheelchair stroller, crutch(es), cane or other mobility/ambulation aid at all times. The word "unable" is used in its literal sense. The fact that one of these mechanical aids facilitates movement is not sufficient.

The applicant is unable to move about without use of the following aid:

☐ Wheelchair ☐ Wheelchair Stroller ☐ Cane ☐ Crutch(es)
☐ Walker ☐ Other ambulation aid (describe) _____

Diagnosis:

☐ **Loss of Both Hands** – By reason of amputation or anatomical deformity, the person lacks both hands.

☐ **Mental Retardation and/or Other Organic Mental Capacity Impairment [The opinion must be given by a physician, medical social worker, or mental retardation service agency.]** The scores specified below refer to those obtained on the W.A.I.S., and are used only for reference purposes. Scores obtained on other standardized individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning:

- ☐ The person is mentally incapacitated such that he or she is dependent upon others for personal needs (e.g., toileting, eating, dressing, or bathing) **AND** is unable to follow directions, such that the use of standardized measures of intellectual functioning is precluded; or
- ☐ Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 59 or less; or
- ☐ Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 60 to 70 **AND** either (a) is unable to perform routine repetitive tasks; or (b) has another mental capacity impairment that imposes additional and significant limitation of mobility or gait.

☐ **Other Organic Mental Capacity Impairment** – The person experiences mental incapacity due to an organic cause(s) that imposes significant limitations of ambulation or gait.

Diagnosis:

I estimate that the duration of the applicant's disability(ies) will be:

☐ Permanent (more than 12 months)
☐ Temporary (more than 3 but fewer than 12 months)

Physician's/Certifier's Signature: Date:

AUTHORIZATION TO DISCLOSE MY HEALTH INFORMATION

1. I hereby authorize: physician/certifier name: _____

_____

Affiliation: _____

Address: _____

Tel. No.

to disclose the information as specified in paragraph 2 to: MTA Reduced-Fare Program, 130 Livingston Street, Brooklyn, NY 11201-9625.

2. (a) You are authorized to complete the "physician/certifier certification" section of my MTA Reduced-Fare Program application and send it to the MTA; and, if contacted by MTA, you are authorized to discuss with a representative of the MTA Reduced-Fare Program the information you have provided in the "physician/certifier certification."

(b) This authorization is effective until the date of the termination of my receipt of MTA Reduced-Fare benefits.

(c) I am requesting that you disclose this health information for the purpose of enabling the MTA to determine my eligibility for reduced-fare transportation benefits.

3. (a) I understand that my authorization is voluntary and that I may revoke it at any time by notifying you in writing. I understand that if I do so, it is effective only to prevent any additional disclosure after the date I give you my notice. It does not apply to disclosures that you made while my authorization was in effect.

(b) I understand that once my health information is disclosed as authorized by me in this form, it may no longer be subject to privacy protections if the authorized recipient is not obligated under law to protect the privacy of my health information.

(c) I understand that you may not condition my treatment, payment, enrollment or eligibility for benefits from you on my granting an authorization for disclosure/release of my health information.

_____

Signature of Individual (applicant for the MTA Reduced Fare Program) Date:

Print the name and address of the individual (applicant for reduced fare) whose health information is to be disclosed:

_____

Name:

_____

Address:

_____

Tel. No.:

If this form has been signed by a personal representative, he/she must complete and sign the following:

I am the personal representative of the individual requesting disclosure of health information whose name and address appear above. This individual has authorized me to complete this form on his/her behalf. My relationship to the individual is as follows (e.g., parent, guardian, attorney, friend, etc.):

_____

Signature of Personal Representative: Date:

_____

Print Name of Personal Representative: Tel. No.

_____

Address:

HIPAA-Compliant

MTA Reduced-Fare MetroCard

Conditions of Use and Other Important Information

for a Metropolitan Transportation Authority Reduced-Fare MetroCard (RFM) issued to people 65 years of age and older and people with disabilities. This program is managed by MTA New York City Transit.

Valid Use: RFM can be used to pay fares on all MTA New York City Transit subways, NYC Transit local buses, express buses only during non rush hours, MTA Staten Island Railway, Nassau Inter-County Express Bus (NICE), MTA Bus, Roosevelt Island Tram, Westchester Bee-LIne local buses and express Bee-Line BxM4C buses only during non rush hours.

The RFM is valid identification for eligibility in the reduced-fare programs of the MTA Long Island Rail Road and MTA Metro-North Railroad, anytime except weekday rush hours to New York City terminals. To receive the reduced fare, show the RFM to train personnel or station agents when purchasing your ticket.

Expiration Dates: Reduced-Fare MetroCards expire on the date printed on the back of the card. As long as you actively use your card, NYC Transit automatically sends you a new RFM before the expiration date.

The full value on an expired RFM may be transferred to a new RFM at a subway station booth. Any remaining value that is not transferred to a new RFM within two years after the expiration date on the original RFM will be surrendered by, and unavailable to, the card holder.

Trouble Using RFMs: An RFM that does not work or is damaged should be returned to MetroCard Customer Claims. Ask a station booth agent or bus operator for a prepaid envelope in which to return your card to us. In the envelope you'll find a form to fill out so you can describe your RFM problem.

If you prefer, you may bring your damaged RFM to the MetroCard Customer Service Center at 3 Stone Street in downtown Manhattan, 9 AM to 5 PM, Monday to Friday.

If you cannot get a prepaid mailer, send the damaged card to:

MetroCard Customer Claims
130 Livingston Street
Brooklyn, New York 11201-9625

Be sure to include your name, address and phone number, your damaged RFM, an explanation of the problem and the address to which the new RFM should be sent.

The holder assumes the risk of loss until the card is received by either MetroCard Customer Claims or the MetroCard Service Center.

Change of Address: Notices and replacement cards will be sent to you at the address you provide. You must inform us promptly, in writing, of any change of address.

Lost or Stolen RFMs: Immediately report a lost or stolen RFM by calling the MetroCard Customer Service Center, 718-330-1234, 6 AM to 10 PM or via our MetroCard eFIX system at www.mta.info. Any value or unlimited rides on your card will be transferred to your replacement RFM after the old RFM has been frozen and any balances verified.

Restrictions: An RFM may be used only by the person to whom it has been validly issued. Use of the RFM by any other person may result in forfeiture of the card and its remaining balances, plus civil and/or criminal penalties.

There are no refunds of money remaining on RFMs. Money remaining on an expired card may only be transferred to a new card within two years of the expiration date. Money from a full-fare MetroCard cannot be transferred to a temporary or permanent RFM. No redemptions or exchanges will be given for an RFM that has been altered or tampered with, or whose value cannot be verified.

The City of New York, the State of New York, the County of Westchester and the Metropolitan Transportation Authority and its subsidiaries and affiliates, including New York City Transit, are not liable for any special or consequential damages associated with or resulting from the failure, malfunction, or disabling of the RFM or the MetroCard system.

The MTA Reduced-Fare MetroCard and its use are subject to all tariff provisions, rules and regulations of the New York City Transit Authority and its affiliates, and Westchester County Bee-Line System.

For more information, call 718-330-1234 6 AM to 10 PM. If you are deaf or hard of hearing, use the free 711 relay or your preferred relay service provider to contact us. Have the card at hand so you can read the serial number and expiration date to the customer service agent who assists you.

The EasyPay Option– Sign up for EasyPay automatic refills

(All payment information will be kept strictly confidential.)

Start paying for your rides with $10. Your account will be automatically replenished whenever the balance goes below $10. Your account immediately converts to unlimited rides when the required number of subway or local bus rides is taken within a 30-day billing period.

Questions? Call 1-877-323-7433

First Name

Last Name

Date Of Birth – –

Telephone ☐ **Home** ☐ **work** ☐ **other** – –

Payment Options (choose one) ❑ Credit ❑ Debit Card

☐ American Express ☐ Discover ☐ MasterCard ☐ Visa

Credit/Debit Card Number

Expiration Date /

I authorize MTA New York City Transit to charge this credit/debit card for my EasyPay MetroCard refills.

Signature Date

Card holder signature (if different)

Applications without Credit/Debit Card authorization signature will be returned to you.

I am a visually impaired customer and wish the following statement:
(check one) ❑ Large Type ❑ Braille

For further information or additional copies of the application, call 718-330-1234.
If you are deaf or hard of hearing, use the free 711 relay or your preferred relay service provider to contact us. Or visit mta.info

Before Mailing the Application include:

1 – A recent photograph
2 – A copy of proof of age or Medicare Card
3 – A Notary Public
4 – Affirmation Signature (page 2)

Mail completed application to:

Metropolitan Transportation Authority
Reduced-Fare Program
130 Livingston Street
Brooklyn, New York 11201-9625

For Office Use Only

Disk # _____ Image # _____

Examiner's Signature _____