



## Application for the Maryland Transit Administration's Reduced Fare Program

This information will be used to determine the applicant's eligibility for the Maryland Transit Administration's (MTA) Reduced Fare Program for people with disabilities. The MTA will assess all information provided and determine eligibility and duration for participation in the MTA Reduced Fare Program.

To qualify as a disabled individual, the applicant must, by reason of illness, injury, congenital malfunction, or other disability which is expected to last 90 days or longer, be unable to utilize mass transit as effectively as others. Conditions which **do not qualify** are: pregnancy, obesity, controlled epilepsy, contagious diseases which pose a danger to other passengers, and less severe mental illnesses. The applicant must fill out Section 1 and have his/her physician or healthcare professional fill out and sign Section 2 of this application.

### SECTION 1: Applicant Information and Release

Mr./Ms. First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Current Disabled I.D. Holder: Yes \_\_\_\_\_ No \_\_\_\_\_

By signing below, I hereby certify, under the penalties of perjury, that the information given above is true and correct. I also authorize my physician or health care professional completing this application to release to the Maryland Transit Administration (MTA) information about my disability in order to verify my eligibility for a Reduced Fare I.D. card.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 2: Medical Certification**

**Section 2 is to be completed by a licensed physician or health care professional. Information on this form will remain on file with the Maryland Transit Administration (MTA) and is not subject to public review.**

**Physicians and Healthcare Professionals**

Applicants who are eligible for the reduced fare program must meet the following definition: “individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are nonambulatory 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.” 49 C.F.R. § 609.3.

The criterion for eligibility is not the applicant’s diagnosis per se; it is the functional ability of the applicant to use regularly scheduled MTA transit service. If the applicant is able to use such service but experiences extreme difficulty in doing so due to his/her medical condition, he is eligible. If the functional limitation that results from the medical condition is presently corrected by medical treatment, such as medication or prosthesis, the applicant does not qualify. If a temporary (greater than 90 days, but less than 1 year) qualifying condition exists, please describe the nature and expected duration. If the condition persists longer than the projected date, the applicant may re-apply.

Low income or substance abuse does not qualify an individual for reduced fare.

**Physician/Healthcare Professional’s Name:** \_\_\_\_\_

**Facility Name:** \_\_\_\_\_

**License Number:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone Number: (W)** \_\_\_\_\_ **(C)** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**1. Disability**

Provide detailed and specific explanation of applicant’s disability and how it specifically impairs his/her ability to use MTA’s transit services (Bus, Metro, and Light Rail).

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**2. What is the expected duration of the disability?**

\_\_\_\_\_ **Temporary:** Short-term conditions lasting for at least 90 days but likely to improve within one year. Please check timing below:

- \_\_\_\_\_ 3 month’s
- \_\_\_\_\_ 6 month’s
- \_\_\_\_\_ 9 month’s
- \_\_\_\_\_ 1 yr

\_\_\_\_\_ **Permanent:** Conditions with no expectation of improvement.

**Verification and Authorization:**

**I hereby certify, under the penalties of perjury, that the information given above is true and correct. I understand that the MTA will rely upon this information in making a determination as to the eligibility of participation in the program.**

\_\_\_\_\_  
**Printed Name of Physician/Healthcare Professional**

\_\_\_\_\_  
**Signature of Physician/Healthcare Professional**

\_\_\_\_\_  
**Date**

<b>Office Use Only</b>
Card Number: _____
Exp. Date: _____ Category: _____
Approved By: _____
Issue Date: _____