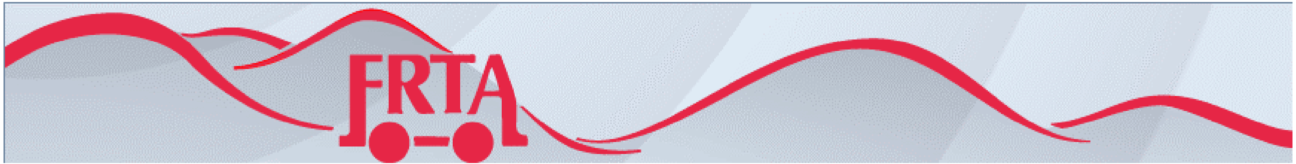

12 Olive St, Greenfield, MA 01301 www.frta.org Tel: (413)774-2262 Fax: (413)772-2202

Dear Applicant,

Enclosed you will find an application for a Statewide Transportation Access Pass. If approved, this pass entitles you to reduced fares offered by the Commonwealth's Regional Transit Authorities while riding on their fixed bus routes.

Upon completion of your application, please mail it to our office at 12 Olive St. Greenfield, MA 01301. ***We will not accept faxed copies*.**

Depending on the nature of your disability, you will be issued either a one-year or a three-year pass.

All applications take approximately 7 days to process. You will receive written notification in the mail. If approved, you will be instructed to call our office to schedule an appointment for your ID, asked bring two forms of identification along with $3.00 cash or money order.

Do not hesitate to contact our office at (413) 774-2262 if you have any questions or need assistance in completing this application.

Commonwealth of Massachusetts/Reduced Fare Program

APPLICATION FOR FRTA TRANSPORTATION ACCESS PASS

1. PLEASE PRINT. COMPLETE SECTION A BELOW:

PART A: APPLICANT INFORMATION

NAME: ________________________________ DATE: __________

STREET ADDRESS: ____

CITY: ________________________ STATE:_____ ZIP:____________

TELEPHONE: ( ) ______________ RENEWAL: ___YES___NO

DATE OF BIRTH: __________

2. COMPLETE PART B ON THE NEXT PAGE IF YOU ARE:

- Over Sixty Years of Age with Applicable Documentation
- A Current ADA PARATRANSIT Customer, or
- A Veteran with a Disability Rating of 70% or greater
- A Valid Medicare Card Holder (Red, White, Blue Card Not MASSHEALTH)
- Clients of the following agencies: Present original letter on agency letterhead, from authorized agency representative (or vendor) verifying status as a current client.
  - DMH/Department of Mental Health (including DMH vendors)
  - DDS/Department of Developmental Services
  - MRC/Massachusetts Rehabilitation Commission

If you are one of the above, it is not necessary to have Part C completed. Simply complete parts A and B, and submit this application to FRTA for processing (Go to #4 below.)

3. If you are ***not*** in one of the categories mentioned in #2 above, you must bring this application to a licensed/certified health care professional to complete part C for the health care certification.

   Examples of licensed/certified health care professionals include those who are familiar with your disability and are licensed or certified in their field, such as Medical Doctor, Licensed Social Worker, Psychologist, Audiologist, Registered Nurse, Psychiatrist.
4. Once this application is completed, return it to the FRTA. The FRTA will review the information to determine your eligibility. You will receive notification within 7 days. We will not accept faxed copies.

Name of Applicant: ______________________ **FRTA**

PART B: TO BE COMPLETED BY APPLICANT

CHECK ONLY **ONE** OF THE FOLLOWING:

- ❑ I AM A MEDICARE CARDHOLDER. I HAVE ATTACHED A PHOTOCOPY OF MY CARD. (Please note: MassHealth is not the same as Medicare. Do not attach a copy of MassHealth card).
- ❑ I HAVE AN ADA ELIGIBILITY CARD. I HAVE ATTACHED A PHOTOCOPY OF MY CARD.
- ❑ I AM OVER THE AGE OF 60. I HAVE ATTACHED A PHOTOCOPY OF MY LICENSE OR OTHER PROOF OF AGE.
- ❑ I AM A DMH, DDS OR AN MRC CONSUMER. I HAVE ATTACHED MY ORIGINAL LETTER ON AGENCY LETTERHEAD AS PROOF OF AN EXISTING CLIENT.
- ❑ I AM A VETERAN WITH A DISABILITY RATING OF 70% OR GREATER. I HAVE ATTACHED AN ORIGINAL LETTER FROM THE VA, SIGNED BY A VETERAN'S SERVICES OFFICER, WHICH SPECIFIES MY DISABILITY RATING.

****If you checked one of the above boxes, then you do not need to have part C completed****

- ❑ I DO NOT FALL INTO ANY OF THE ABOVE FOUR CATEGORIES; THEREFORE I HAVE PROVIDED THE FRTA WITH INFORMATION FROM MY LICENSED HEALTH CARE PROFESSIONAL (PART C).

I AGREE TO RELEASE THIS INFORMATION TO THE FRTA FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR A TRANSPORTATION ACCESS PASS. THE FRTA RESERVES THE RIGHT TO CONTACT THE LICENSED PROFESSIONAL COMPLETING THIS APPLICATION.

SIGNATURE OF APPLICANT: ________________________________

Name of Applicant: ________________________　　　　**FRTA**

PART C. TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

Please Print:

Health Care Professional's Name: _______________________________________
License Number/State: _____________________________
Business Address: _________________________________
City/Town: _________________ State: _____________ Zip: _________
Telephone #: _____________________

Please define the applicant's disability:
____
____
____

Refer to the attached criteria to answer the questions below and check mark the appropriate responses:

1. Is the applicant disabled according to at least one of the Criteria listed in the attached?
   Yes ___ No ___

   If yes, fill in the criteria number 1 – 9 ______

2. Is the disability a permanent condition? Yes ___ No ___
   If no, estimated length of disability (in months) ____________

3. Is the applicant, despite his/her disability, able to use the FRTA fixed route bus service?
   Yes ___ No ___

4. Which of the following mobility aids or equipment do you use to help you get where you need to go? (please check all that apply).

   - ❑ Manual Wheelchair
   - ❑ Power Scooter
   - ❑ Cane
   - ❑ Prosthetic Device/Brace
   - ❑ Guide Cane
   - ❑ I do not use a mobility aid
   - ❑ Other (specify): _____________________________
   - □ Power Wheelchair
   - □ Walker
   - □ Crutches
   - □ Respirator/Oxygen Tanks
   - □ Service Animal (Guide dog, etc..)

5. In addition to the above, does the applicant require the aid of an attendant when going from the house to the curb/vehicle? Yes ___ No ___

Name of Applicant: ______________________ **FRTA**

CRITERIA FOR DISABLED INDIVIDUALS TO QUALIFY FOR THE STATEWIDE TRANSPORTATION ACCESS PASS

1. Any individual who cannot walk more than 200 feet to a bus route or final destination without the use of a mechanical aid (Crutches, walker etc.).

2. Any individual who uses a wheelchair.

3. Any individual who has less than 20/20 vision with best correction or a field restriction of 10 degrees or less. (Any legally blind applicant must have a certificate of blindness from the Mass Commission for the Blind (800) 392-6450).

4. Hearing Impairments: Deafness or hearing loss of 90db or greater in the 500, 1,000 and 2,000 HZ ranges.

5. Any individual who cannot walk more than 200 feet to a bus route or final destination because of a neurological, muscular-skeletal, pulmonary or cardiovascular disorder.

6. Any individual who has a developmental disability or an emotional disorder. Eligibility for emotional disorders is as follows:

   6a. Emotionally disturbed person who is living in a community residence or boarding home and participating in a sheltered workshop or day hospitalization program.

   6b. Living at home and participating in a sheltered workshop or day hospitalization program.

7. Any individual who is an amputee.

8. Any individual who requires kidney dialysis treatment.

9. Any individual who has a valid Medicare Card (see instructions for Medicare cardholders).

I hereby claim that the above information is accurate and true to the best of my knowledge.

Licensed Healthcare Professional Signature: ____

Date: ____________________

Rev. December 2017