City of Mt. Vernon
Transportation Services

PO Box 70

Mount Vernon, MO 65712

(417)466-2151

Person with Disabilities Reduced Bus Fare

Reduced Fare card Application

Please print Legible

_____ _____ _____
Last Name First Name Middle Initial

_____ _____
Street Address Apt. #

_____ _____ _____
City State Zip

_(_____)_____ ☐ ☐ Date of Birth ☐☐ ☐☐ ☐☐☐☐
Area Code Phone Number M F Month Day Year

Check the appropriate box and sign below:

☐ First Card. If you have not had a Persons of Disabilities Reduced Fare card before, check this box. Complete the information above and pay $1 for the ID Card, You must have your physician or other qualified certifying agent complete and sign the back side of this application.

☐ Renewal Card. Complete the information above and pay $1 for the ID Card.

☐ Replacement Card. If you have lost your Fare card, or if your card was stolen, check this box. A replacement card costs $5 the first time, $10 the second time or $15 the third time. Additional replacements after the fourth card will be at the discretion of the issuing agent. Certification is not required for the replacement cards. You must have correct fee with application.

I understand that my Persons with Disabilities Reduced Fare Card is not transferable to other person and that City of Mt. Vernon Transportation reserves the right to determine qualifications for issuing cards in accordance with the terms and conditions stated on the reverse side of this application. **This card will be valid for 3 years from the date of issue.**

_____ _____
Signature Date

Return this completed application with the correct fee to City of Mt. Vernon Transportation.
If you are applying for your first Reduced Fare Card, the back of this form must be completed and signed by your physician or other certifying agent. **We will need to take a picture to complete this application.**

For Office use only

Card No. ☐☐☐☐☐☐ Issue Date ☐☐ ☐☐ ☐☐ Amount Paid ☐☐ ☐☐ Issuer ☐☐☐ Expiration Date ☐☐ ☐☐ ☐☐

Additional
Notes:_____
_____

For Physician or Certifying Agent

To qualify for the City of Mt. Vernon Transportation Persons with Disabilities Program, your client/patient must have a physical or mental condition that falls within the medical eligibility criteria listed below.

Is this disability permanent: ☐ Yes ☐ No Has condition existed for at least 90 days: ☐ Yes ☐ No

A. Non-Ambulatory Disabilities

1. Impairments which requires the individual to use a wheelchair.

B. Semi-Ambulatory Physical Disabilities

1. **Restricted mobility**. Disabilities requiring the permanent use of a cane, crutches, long leg brace or other orthopedic appliances to assist an individual in moving about.
2. **Arthritis.** American Rheumatism Association criteria may be used as a guideline for the determination of arthritic disability; Therapeutic Grade III, Functional Class III, Anatomical State III or worse is evidence of arthritic disability.
3. **Loss of extremities**. Anatomical deformity of or amputation of hands, one hand and one foot, or loss of major function.
4. **Cerebrovascular accident**. Ongoing debilitating effects following occurrence of accident, or Cerebral Palsy.
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.
7. Other. Please specify:_____
   _____
   _____

C. Visual Disabilities

1. **Legally Blind**. Visual impairment that is bilateral and not correctable with lenses.
2. **Construction 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 fields efficiency is 20 degrees or less.

D. Hearing Disabilities

1. **Legally deaf**. Hearing impairment that is bilateral and not correctable with hearing aid.

E. Mental Disabilities

1. **Developmentally disabled.** Mental disability that originated before age 18.
2. **Epilepsy.** Grand mal or Psychomotor, Persons who are seizure-free for continuous period of six months are disqualified
3. **Autism.** Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli and very inadequate social relationships.
4. **Neurological disabilities.** Neurological and physical impairments not controlled by medication (i.e., cerebral palsy or multiple sclerosis).
5. **Organic brain syndrome/emotionally disturbed or Bi-Polar.** Mental disturbances that require boarding or home care, funded work activity or workshop.
6. **Schizophrenia**

F. Disability Benefits Recipient

1. **Medicare Cardholder**.(Please bring a **copy** of your Medicare Care. **State Medicaid recipients do not qualify**.)
2. **Disabled veteran certified at 50 percent or greater.**
3. **Social Security Disability**

City of Mt Vernon Transportation reserves the right to confiscate a reduced fare card that has been used improperly. Reduced fare cards should not be loaned or borrowed**. A confiscated card will not be returned or replaced.** This application is the property of City of Mt. Vernon Transportation.

Please Print Physician's Name or Certifying Agent

Address

_____ _____

Area Code Phone No. Physician's State License No. Required