REDUCED FARE PROGRAM APPLICATION FOR A PERSON WITH A DISABILITY

To be certified by a licensed physician or nurse practitioner only.

NJ TRANSIT REDUCED FARE PROGRAM
One Penn Plaza East, 5th Floor, Newark, New Jersey 07105

Phone (973) 491-7112
Fax (973)609-1753
Email Reducedfare@NJTransit.com

INSTRUCTIONS

APPLICANT

Fill out the information in the "To be completed by Applicant" section and submit to a licensed physician or nurse practitioner for certification.

Eligible applicants will receive a Reduced Fare ID Card through the mail approximately four weeks after the physician has mailed in the application. A booklet of Reduced Fare Tickets may be obtained at participating banks, savings and loan associations, and authorized state and county agencies.

PHYSICIAN

Please complete all items (Items 1-7) in section marked "Physician Certification" and mail directly to:

NJ TRANSIT
Reduced Fare Program
1 Penn Plaza East, 5th Floor
Newark, NJ 07105

Under "Ambulatory Disabled" (Item 6), check the subcategory that makes your client eligible and describe in detail the nature of the impairment or disability in the space provided.

Unless a category is specifically checked off and, in the case of "Ambulatory Disabled" more specifically categorized, we cannot accept this application. If there is no category that your patient fits into, he or she is not eligible for the program. These criteria have been set and are mandated by the law.

You are assured that you are not liable to NJ TRANSIT in any way as the result of furnishing your certification.

ELIGIBILITY CRITERIA

General Provisions:

1. The Eligibility Criteria listed on page 2 of the application are the sole basis for the determination of a disability for the NJ TRANSIT Reduced Fare Program.

- **A.** An applicant 62 years of age or older who is not enrolled, may enroll in the Reduced Fare Program through the Senior Citizen Program. Senior Citizens applications are available at most banks, savings and loan associations and authorized state and county agencies.

2. Reduced Fare Identification Cards for persons with permanent disabilities are valid until expiration date shown on card.

3. NJ TRANSIT reserves the right to verify Certification Forms by contacting persons completing the forms.

4. Any fees charged for the completion of Certification Forms are not the responsibility of NJ TRANSIT.

5. Certification Forms will be confidential records and kept on file at NJ TRANSIT during the period of eligibility.

6. The criteria for eligibility on the application are in accordance with the following definition: "A person with a disability means any individual who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, is 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."

Exclusions

Persons whose sole incapacity is:
1. Pregnancy
2. Obesity
3. Acute or chronic alcoholism or drug addiction
4. Contagious diseases are specifically excluded from discount fare eligibility

For assistance in filling out this application, please call the NJ TRANSIT Reduced Fare Office Monday - Friday, 8:00AM- 4:00PM at (973) 491-7112.

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NO._____

REDUCED FARE PROGRAM
APPLICATION FOR A PERSON WITH A DISABILITY

Disability Information Release Authorization:

As a part of my NJ Transit Reduced Fare Application Assessment, I realize that a licensed health professional, holding physician-level credentials in the area of my disability must verify my present medical condition. Therefore, by signing this form, I give my consent to release to NJ Transit's Reduced Fare Program and its authorized designee of any records or information maintained by the licensed health care professional relevant to a determination that I am eligible to receive NJ Transit Reduced Fare. This authorization is effective for so long as NJ Transit Reduced Fare Program is reviewing my application; and/or to determine my continued eligibility for the NJ Transit Reduced Fare Program. This authorization to release medical information is subject to written revocation by me at any time. In the absence of my revocation, this authorization will only be valid for four (4) years. I understand that any fees associated with the completion of this request are my responsibility.

_____ _____

Applicant Name (PRINT) **Applicant Date of Birth**

_____ _____

Applicant Signature **Today's Date**

_____ _____

Parent/ Legal Guardian Signature **Today's Date**

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NO._____

REDUCED FARE PROGRAM
APPLICATION FOR A PERSON WITH A DISABILITY

TO BE COMPLETED BY APPLICANT ☐ First Time Applicant ☐ Renewal ☐ Replacement

1. Name_____
(Last) (First) (Middle)

2. Address_____
(Street) (Apt.)

_____
(City) (County) (State) (Zip code)

3. Sex: ( ) Male
( ) Female

4. Height_____

5. Date of Birth_____ **6. Telephone Number**_____

7. Signature of Applicant_____

☐ Check here if you are signing as a personal representative and complete below. This **ONLY** applies if someone other than the person with Disability signed above.

Print Name of Personal Representative _____**Phone Number** _____

Signature of Personal Representative _____**Date** _____

Relationship to Applicant _____

PHYSICIAN CERTIFICATION (to be completed by licensed physician/ practitioner only)

1. Name_____

2. Office Address_____
(Street) (Suite)

_____
(City) (State) (Zip Code)

3. Telephone Number _____

4. Licensure Title _____**Specialty**_____

5. License Number _____State Issued_____

)

For Internal Use Only: _____**Staff initials** _____**Date** ____**Approved** ____**Denied** ___**Incomplete**

PHYSICIAN CERTIFICATION (continued)

ELIGIBILITY CRITERIA

The impairment or disability is considered:

5. Permanent ( ) **Temporary ( )**

Estimated Period of Disability

From _____ to _____
(Date) (Date)

6. ( ) Non-Ambulatory Disabled

Any person whose incapacity or disability 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.

( ) Semi-Ambulatory Disabled

Any person whose incapacity or disability 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.

( ) Ambulatory Disabled

Any person whose disability relates to a degree of visual, audio, physiological, mental or psychological disability or impairment as specified below, and for whom private personal transportation poses an unreasonable difficult or danger.

( ) Cerebrovascular accident (stroke)

( ) Pulmonary disability - (obstructions/ restrictions) that affect mobility. Those with PFT outcome < 50% of predicted values (FEV1; FVC; %FEV1; FEF25%-75%). Dyspnea occurs during usual activities of daily living; climbing a flight of stairs or walking 100 yards; with the slightest exertion; or even at rest.
( ) Cardiac disability
( ) Sight disability - those persons whose vision in the better eye after correction is 20/200 or less; and those persons whose visual field is contracted (commonly known as tunnel vision) to 10 degrees or less from a point of fixation, or the widest diameter subtends an angle no greater than 20 degrees.
( ) Hearing - loss is 90 dba or greater in the 500, 1000, 2000 Hz ranges.
( ) Faulty coordination from brain,spinal, peripheral nerve injury or arthritic condition.
( ) Epilepsy - petit and grand mal
( ) Autism
( ) Cerebral palsy
( ) Intellectual Disability - Those with I.Q.more than two standard deviations below the norm.
( ) Psychiatric Disabilities -This section applies to those individuals who suffer from a serious, long term mental illness that

- includes a substantial disorder of thought, memory, perception, or orientation
- grossly impairs judgment, behavior, capacity to recognize
- greatly impacts ability to meet ordinary/independent life support needs of foods, shelter, clothing, management of finances, and health care.

( ) ***Other - please specify the disability that impairs mobility.***

_____

_____

_____

7. Does this person's disability require that he or she use a personal care attendant (PCA) in order to use public transportation?
( ) yes ( ) no

8. Physician/ Practitioner Signature _____ **Date**_____