Application Instruction for the Reduced-Fare Program

The Niagara Frontier Transportation Authority (NFTA) administers a Reduced-Fare Program for persons with disabilities who have been certified to have a qualifying disability as defined by the Federal Transit Administration or who have been certified as eligible by a third party as part of the Community Care program (childcare subsidy program).

Eligibility

The Federal Transit Administration requires that persons with the following disabilities be provided with reduced-fare transportation:

- Serious Mental Illness (SMI) and receiving Supplemental Security Income (SSI) or Supplemental Security Aid to the Disabled (SSI-AD)
- Receiving Medicare for any reason
- Hearing Impairment
- Ambulatory disability
- Loss of both hands
- Intellectual Disability and or other organic mental capacity impairment

In addition, persons may be certified as eligible by Erie County or Niagara County as part of the Community Care program. This program offers reduced fare passes to families receiving childcare assistance through the New York State Child Care Block Grant Program Categories 2 and 3 (Child Care Subsidy Program).

All applicants are required to forward to the Reduced-Fare Program a completed Reduced-Fare application, documentation of their disability, valid photo identification and $2.00 fee. Permanent cards are valid for four (4) years. Community Care-issued cards are valid for one (1) Year.

Verification of Disability

Documents from the following agencies and health care professionals may be submitted to verify disabilities

- Veterans Administration 100 percent totally and permanently disability rating. Or if you have less than a 100 percent rating proceed to Part II.
- Social Security Administration
- Medicare Card (red, white and blue)
- Medicaid Aid to the Disabled
- NYS Commission for the Blind
- Supplemental Security Aid to the Disabled (SSI-AD)
- U.S. Assoc. for the Education & Rehabilitation of the Blind & Visually Impaired
- Olmsted Center for the Visually Impaired
- New York State Office for People With Developmental Disabilities (OPWDD)
- Epilepsy Foundation
- Certified Social Worker, Case Manager or Rehabilitation Counselor
- Certified Occupational or Physical Therapist
- Physiatrist (not a Psychiatrist)
- Audiologist or St. Mary's School for the Deaf
- Signed and stamped Community Care Eligibility Form from Erie County or Niagara County

Temporary Reduced-Fare Cards
If you are issued a temporary Reduced-Fare card, you will have to reapply for a new card every year (every twelve months) upon the card's expiration date. Documentation of compliance from a recognized treatment program will also be required prior to the renewal of temporary cards. Community Care reduced fare cards are valid for one year.

Conditions of Use
The Reduced-Fare card is valid only if you are disabled as stated on your application. The Reduced-Fare card can only be used by the person to whom it was 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 Program automatically ceases; you are no longer permitted to use the Reduced-Fare card, and you must return the card to the NFTA.

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

Return Completed Application to:

Niagara Frontier Transportation Authority
Reduced-Fare Program
181 Ellicott Street
Buffalo, New York 14203

NFTA Special Services/Reduced Fare
181 Ellicott Street
Buffalo, New York 14203

APPLICATION FOR REDUCED-FARE PROGRAM
PART I

☐ New Application ☐ Renewal Application

The information on this form will be used for the purpose of determining eligibility for the Reduced-Fare Program.

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Month/Day/Year

If the application is completed by an advocate/personal representative of the applicant, this person must complete the following:

Name of Personal Representative: _____

Address: _____

Telephone Numbers: _____

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

_____

DISABILITY AFFIRMATION

My application for Reduced-Fare is based on one of the following:

- ☐ I am a recipient of Medicare. (Attach a copy of your Medicare card)
- ☐ I currently receive Supplementary Security Income (SSI) with SSI/SMI benefits from the Social Security Administration. (Attach a copy of your SSI award letter from within the past year)
- ☐ I currently receive Social Security Disability Insurance (SSD) with benefits from the Social Security Administration (Attach a copy of SSD award letter from within the past year)
- ☐ I am a senior citizen 65 years or older (Attach proof of age documentation: e.g. birth certificate, driver's license, passport, state issued ID)
- ☐ I am a disabled veteran and have enclosed my documentation from the Veterans Administration verifying 100 percent totally and permanently disability or my health care provider has completed Part II
- ☐ I am an approved participant in the Community Care Program (New York State Child Care Subsidy recipient)

DISABILITY AFFIRMATION (continued)

My application for Reduced-Fare is based on the following disability (check all that apply)

If you check any of the following boxes, a physician, licensed Health Care Provider or Qualified Intellectual Disability Professional MUST complete Part II.

- ☐ My eligibility is based on "Blindness" as defined in Part II of this application. I am registered with the New York State Commission for the Blind and Visually Handicapped. My NYSCBVH Registration Number is _____.
- ☐ Hearing Impairment
- ☐ Ambulatory Disability
- ☐ Loss of Both Hands
- ☐ Intellectual Disability or other Mental Capacity Impairment
- ☐ Veteran (less than 100% disability rating)
- ☐ Not applicable (Community Care program)

All applicants are required to forward to the Reduced-Fare Program a completed Reduced-Fare application, documentation of their disability, valid photo identification and $2.00 fee. Permanent cards are valid for four (4) years.

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 to my 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 NFTA 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 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 NFTA may discontinue or change its Reduced-Fare Program without notice. If the NFTA determines that I have not followed the Reduced-Fare Program Conditions of Use, I understand that my Reduced-Fare card 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 card 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 Date

NFTA-METRO
Serving Buffalo Niagara

APPLICATION FOR REDUCED-FARE PROGRAM
MEDICAL CERTIFICATION
PART II

To be completed by a physician, Licensed Health Care Provider or a Qualified Intellectual Disability Professional (QIDP). Not required for Community Care program.

Physician/ Certifier Name: _____
LAST FIRST MIDDLE INITIAL

Office Address: _____

Suite No: _____

City: _____ State: _____ Zip Code: _____

Best Time to Call: _____

Telephone No: _____

❑ State Professional License No. _____

or

❑ I am a Qualified Intellectual Disability Professional (QIDP).

DISABILITY VERIFICATION

I am familiar with the Applicant and have examined all applicable documentation (fully identified in the Applicant's Section of 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 a 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 as angle of greater than 20 degrees, shall be considered as having central visual acuity of 20/200 or less.

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

- Average hearing threshold 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, 1000 and 2000 HZ.
- Speech discrimination scores of 40% or less in each ear.

❑ **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 the use of the following aid:
  –wheelchair – wheelchair stroller –cane –crutch(es)
  –walker –other ambulation aid _____

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

❑ **Intellectual Disability and/or Other Mental Capacity Impairment** – 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 organic cause(s) to impose significant limitation in the utilization of mass transit facilities or services effectively.

In all cases please check one of the following:

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

- ❑ Permanent (more than 12 months)
- ❑ Temporary (more than 3 months, but fewer than 12 months)

Physician's / Certifier's Signature: _____

Date: _____