

Application for Disability Half Fare Certification

The information obtained in this certification process will only be used to determine eligibility for reduced fare transportation services provided by St. Joseph Transit. Eligibility will be determined by the St. Joseph Health Department. The information contained herein will not be provided to any other person or agency.

Please mail or bring this completed form to:

Kelly Kibirige, RN

City of St Joseph Health Department, Community Health Division

904 South 10th Street, 2nd floor, Suite E

St. Joseph MO 64503

Definition of Disability

“Disability” means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

The phrase “physical or mental impairment” means a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine; or b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

The term physical or mental impairment includes, but is not limited to, such contagious or noncontagious diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism;

The phrase “physical or mental impairment” does not include homosexuality or bisexuality.

The phrase “major life activities” means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work.

The phrase “has a record of such an impairment” means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

The phrase “is regarded as having such an impairment” means a) has a physical or mental impairment that does not substantially limit major life activities, but which is treated by a public or private entity as constituting such a limitation; b) has a physical or mental impairment that substantially limits a major life activity only as a result of the attitudes of others toward such an impairment; or c) has none of the impairments defined in paragraph (1) of this definition but is treated by a public or private entity as having such an impairment.

The term “disability” does not include transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders; compulsive gambling, kleptomania, or pyromania; or psychoactive substance abuse disorders resulting from the current illegal use of drugs.

Department of Transportation, 49 CFR Part 37, Subpart A, Section 37.3, Definitions.

To be completed by applicant:

Name _____

Address _____
Last First Middle Apt No.

City _____ State _____ Zip code _____

Telephone Home _____ Work _____ Cell _____

Date of Birth ____ / ____ / ____

What is the disability that entitles you to be eligible for reduced fare on the transit system?

To evaluate your request it may be necessary to contact your health care provider to confirm the information you have provided. Please complete the following information.

Health Care Provider Name _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

I hereby certify that the information provided in this application is correct and I authorize the St. Joseph Health Department to contact my health care provider to confirm the information I have provided.

Applicant Signature _____ Date ____ / ____ / ____

If this application has been completed by someone other than the applicant, that person must complete this section.

Name _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

Signature _____ Date ____ / ____ / ____

To be completed by Health Department or Health Care Professional

1. Is this condition permanent? Permanent Temporary
If temporary, the expected duration of the condition is until ____/____/____

2. Does applicant use any of the following mobility aids? Please check all that apply.

- Manual wheelchair
- Electric wheelchair
- Powered scooter
- Service animal
- Crutches
- Cane
- Walker
- White cane

3. Does applicant require a Personal Care Attendant (PCA) to assist with non-transportation activities while traveling?

- Yes
- No

4. Can applicant travel ¼ mile without the assistance of another person?

- Yes
- No
- Sometimes

Can applicant travel ¾ mile without the assistance of another person?

- Yes
- No
- Sometimes

Can applicant climb one 11" step without the assistance of another person?

- Yes
- No
- Sometimes

Can applicant wait outside without support for 10 minutes?

- Yes
- No
- Sometimes

5. Are there any other effects of the disability about which transit needs to be aware?
