

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

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..) or because of a neurological, muscular-skeletal, pulmonary or cardiovascular disorder.

Any individual who uses a wheelchair.

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.

Any individual who is considered deaf and whose hearing is uncorrectable by use of a hearing aid.

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

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

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

Any individual who is an amputee.

Any individual who requires kidney dialysis treatment.

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

Commonwealth of Massachusetts/Reduced Fare Program

APPLICATION FOR WRTA 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 a Medicare card holder, over the age of 60, have an ADA eligibility card, or are a Veteran with a disability rating of 70% or greater, it is not necessary to have Part C completed. Simply complete Parts A and B and submit this application to the Clinton Senior Center for processing. (Go to #4 below)

If you are not in one of the categories mentioned in #2 above, you must bring this application to a licensed/certified healthcare professional to complete Part C for healthcare certification. Examples of licensed/certified healthcare professionals include those who are familiar with your disability and are licensed or certified in their field, such as a Medical Doctor, Licensed Social Worker, Psychologist, Audiologist, Registered Nurse, or Psychiatrist, etc...

Once this application is complete, return it to the Clinton Senior Center, 271 Church Street, Clinton, MA 01510. Once the application is received, it will be reviewed to determine your eligibility. You will receive notification within 21 days of receipt.

**WE WILL NOT ACCEPT FAXED COPIES.**

Commonwealth of Massachusetts/Reduced Fare Program

APPLICATION FOR WRTA 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:

A Medicare Card Holder, over the age of 60, have an ADA eligibility card, or are a Veteran with a disability rating of 70% or greater, it is not necessary to have Part C completed. Simply complete Parts A and B and submit this application to the WRTA 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 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 or Psychiatrist (etc.).

4. Once this application is completed, return it to the \_\_\_\_\_

The WRTA will review the information to determine your eligibility. You will receive notification within 21 days. We will not accept faxed copies.

**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 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 complete part C\*\*

- I DO NOT FALL INTO ANY OF THE ABOVE FOUR CATEGORIES; THEREFORE I HAVE PROVIDED THE WRTA WITH INFORMATION FROM MY LICENSED HEALTH CARE PROFESSIONAL (PART C). I AGREE TO RELEASE THIS INFORMATION TO THE WRTA FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR A TRANSPORTATION ACCESS PASS. THE WRTA RESERVES THE RIGHT TO CONTACT THE LICENSED PROFESSIONAL COMPLETING THIS APPLICATION.

SIGNATURE OF APPLICANT: \_\_\_\_\_

FOR WRTA USE ONLY:

Name of Applicant: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

**PART C. TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL**

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 \_\_\_\_\_

Please define the disability:

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

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 \_\_\_

To the best of my knowledge, the information contained in this form is correct.

Physician or Professional's Name \_\_\_\_\_

Physician or Professional's Signature \_\_\_\_\_

Physician or Professional's Office Number \_\_\_\_\_

Physician or Professional's Office Address \_\_\_\_\_

License Number/State \_\_\_\_\_

Licensure Title \_\_\_\_\_

Date \_\_\_\_\_