

# Disabled TAP Identification Card Application

LOS ANGELES COUNTY TRANSIT OPERATORS ASSOCIATION (LACTOA)



## SUBMITTING YOUR APPLICATION

A completed application ready for submission contains the following:

- > A non-refundable \$2 application fee. If applying by mail, please send check or money order made payable to Metro.
- > A current 2" x 2" or 1" x 1¼" full-face photo (no hats or sunglasses) on photo paper attached to box in **SECTION I**.
- > A completed application form: **SECTIONS I, II, III** for all applicants and **SECTION IV AND V** for qualifying medical disability applicants.
- > Photocopy of CA driver's license or CA ID card, and documents proving eligibility in **SECTION III** for all applicants except qualifying medical disability applicants.

Submit your completed application packet in person to any of the Metro Customer Centers listed below or mail to:

- > Metro Reduced Fare Office  
Mail Stop 99-PL-4  
One Gateway Plaza  
Los Angeles, CA 90012-2952

LACTOA Disabled TAP cards will be mailed to eligible applicants within 20 business days after verification has been completed. The LACTOA agencies reserve the right to make final determination of eligibility of Disabled TAP cards. Applications are for internal use only and will not be subject to public review. The card is not transferable.

## METRO CUSTOMER CENTER LOCATIONS (ACCEPTING APPLICATIONS FOR LACTOA DISABLED TAP ID CARDS)

Metro Customer Center	Metro Customer Center	Metro Customer Center	Metro Customer Center
<b>Baldwin Hills/Crenshaw</b>	<b>East Los Angeles</b>	<b>Union Station/Gateway Plaza</b>	<b>Wilshire/La Brea</b>
3650 Martin Luther King Bl, Ste 189 Los Angeles, CA	4501 B Whittier Bl Los Angeles, CA	One Gateway Plaza Los Angeles, CA	5301 Wilshire Bl Los Angeles, CA

## FOR MORE INFORMATION

Visit [metro.net/reducedfares](http://metro.net/reducedfares)  
213.680.0054

The LACTOA Disabled TAP Card Program makes it easy for passengers with disabilities to qualify for reduced fares on all Los Angeles County transit operators (except Dial-a-Ride services). Call 213.680.0054 for eligibility requirements or additional information.

## APPLICATION INSTRUCTIONS

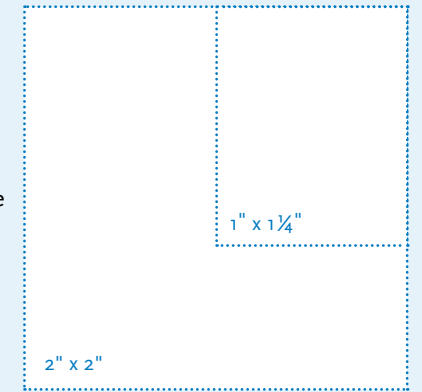
- > All applicants are required to complete **SECTIONS I, II and III** of this application and provide a copy of a valid photo ID.
- > If applicant has a qualifying medical disability (see **SECTION III**), then he or she is also required to complete **SECTION IV** and must request a doctor or other certifying professional to complete and sign **SECTION V**.
- > A non-refundable \$2 application fee. If applying by mail, please send check or money order made payable to Metro.
- > Photocopy of CA driver's license or CA ID card, and documents proving eligibility in **SECTION III** for all applicants except qualifying medical disability applicants.
- > Submit completed application in person or by mail (see last page).

## SECTION I – PHOTO SPECIFICATIONS

> All applications with photos that do not adhere to the guidelines listed below will not be processed.

### TAPE PHOTO INSIDE BOX

- > Full face photo only
- > Photo size 2" x 2" or 1" x 1¼"
- > No hats or sunglasses
- > Photo must fit in space provided (cut to size)
- > Photo must be on photo paper, not photocopy paper



## SECTION II – APPLICANT INFORMATION (TO BE COMPLETED BY APPLICANT)

_____ Last Name	_____ First Name	_____ Middle Name/Initial
_____ Street Address	_____ Apt #	_____ City   State   Zip
_____ Email	_____ Birth Date	_____ Telephone Number

I declare under penalty of perjury under the State of California that the information I have given is true. I understand that I may lose the use of my Reduced Fare TAP card if I misuse the card, or if I mark, tag or damage transit agency property.

_____ Applicant Signature	_____ Date
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## SECTION III – ELIGIBILITY CRITERIA AND MEDICAL RELEASE

Applicants are eligible for the LACTOA Disabled TAP card if one of the following criteria listed below applies to the applicant.

*Note: Applicants who qualify in one of the first four categories must supply a photocopy of the document proving eligibility and a current CA driver's license or CA ID card.*

- \_\_\_\_\_ I have a Medicare Identification Card (Medi-Cal Card not acceptable)
- \_\_\_\_\_ I have a valid California DMV Placard receipt (must have current "valid through" date to be accepted) or Disabled Veterans ID (service connected)
- \_\_\_\_\_ I receive Supplemental Security Income [SSI] or Social Security Disability Insurance [SSDI] benefits (copy of award letter, benefit adjustment letter, benefit check)
- \_\_\_\_\_ I am a Special Education Student in a Los Angeles County program (certification letter on school letterhead signed by the Special Education teacher)

### ----- IF YOU MEET THE ABOVE REQUIREMENTS, YOU CAN STOP HERE -----

- \_\_\_\_\_ I have a qualifying medical disability according to *Social Security Disability* (Requires completion of **SECTION IV and V**)

### ----- CONTINUE TO SECTIONS IV AND V -----

**THIS SIDE TO BE COMPLETED FOR QUALIFYING MEDICAL DISABILITY CRITERIA ONLY**

**SECTION IV – MEDICAL RELEASE CONSENT (REQUIRED FOR MEDICAL DISABILITY CRITERIA ONLY)**

In connection with my application for a LACTOA Disabled TAP card, I hereby authorize Dr. \_\_\_\_\_ to release to the appropriate agency, medical or other pertinent information regarding my disability. The information released will only be used to verify my patient status and the designation of my disability category.

I realize that I have a right to receive a copy of this authorization. I understand that I may revoke this authorization at any time. Unless revoked, this form will permit the health care professional certifying my disability to release pertinent information for up to 60 days after the date appearing below.

Applicant Name (Print) \_\_\_\_\_ Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION V – MEDICAL PROFESSIONAL CERTIFICATION (FOR DOCTOR'S USE ONLY)**

Qualified health care professionals who may certify disabilities listed in **SECTION VI**:

<b>M.D. &amp; D.O. – ALL IMPAIRMENTS, ALL CATEGORIES</b>	<b>AUDIOLOGIST – HEARING IMPAIRMENTS <b>D, P ONLY</b></b>
<b>CHIROPRACTORS – MOBILITY IMPAIRMENTS <b>A, B, D ONLY</b></b>	<b>PODIATRIST – MOBILITY IMPAIRMENTS <b>A, B, C, D ONLY</b></b>
<b>OPTOMETRIST – VISUAL IMPAIRMENTS <b>K, L ONLY</b></b>	<b>CLINICAL PSYCHOLOGISTS – MENTAL IMPAIRMENTS <b>M, N ONLY</b></b>

In order to certify an individual for the LACTOA Disabled TAP card you must:

- > Agree to only certify, as eligible, those individuals who meet the criteria in **SECTION VI**.
- > Upon request, provide verification of the information contained on this application to qualifying agency.
- > Possess the proper professional degree and be licensed in California.

I hereby certify that the applicant's Medical Disability Criteria defined in **SECTION VI** is/are **(CIRCLE ALL LETTERS THAT APPLY)**

**A B C D E F G H I J K L M N O P**

In the space provided below, doctor must indicate in detail applicant's disability. **(REQUIRED)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In my professional judgment the applicant's disability is expected to continue for ( ) years, ( ) months.  
(Note: TAP Identification Cards will not be issued for less than 3 months or more than 3 years.)

I understand that failure to certify applicant disabilities in accordance with the above guidelines will result in cancellation of my certification privileges. I am legally licensed as a \_\_\_\_\_ in the State of California and under the penalty of perjury, I hereby declare that the information provided is true and correct.

**MEDICAL PROFESSIONAL INFORMATION**

Doctor's Full Name \_\_\_\_\_ License No. \_\_\_\_\_  
Address \_\_\_\_\_ Suite \_\_\_\_\_  
City | State | Zip \_\_\_\_\_ Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_  
Signature \_\_\_\_\_ Date of Execution \_\_\_\_\_

**SECTION VI – MEDICAL DISABILITY CRITERIA**

**MOBILITY IMPAIRMENTS**

- A** Non-ambulatory: Requires use of a wheelchair.
- B** Mobility-Aided: Requires use of an AFO or larger leg brace, walker, or crutches to achieve mobility.
- C** Arthritis: Therapeutic Grade III or worse, Functional Class III or worse, Anatomical Grade III or worse.
- D** Amputation/Deformity: Traumatic loss of muscle mass or tendons or x-ray evidence of bony or fibrous ankylosis, joint subluxation or instability of both hands, one hand and foot, or amputation at or above tarsal region.
- E** Stroke: Causing Pseudobulbar Palsy, sustained functional motor deficit of gross/dexterous movement or gait, ataxia affecting two extremities.

**PHYSICAL IMPAIRMENTS**

- F** Respiratory: Class III or greater.
- G** Cardiac: Vascular impairments of Functional Class III or IV and Therapeutic Class C, D or E.
- H** Dialysis: Individuals who require kidney dialysis to live.
- I** Neurological Impairments: As contained in *Disability Evaluation Under Social Security Publication*.
- J** Chronic Progressive Debilitating Disorders: Diseases that are characterized by chronic symptoms such as fatigue, weakness, weight loss, pain and changes in mental status which interfere in daily living activities and **significantly impair mobility**.
  - > Progressive and uncontrollable malignancies
  - > Advanced connective tissue disease such as Lupus Erythematosus, Scleroderma or Polyarteritis Nodosa
  - > Symptomatic HIV: (AIDS or ARC) in CDC defined clinical group IV, Subgroups A-E

**VISUAL IMPAIRMENTS**

- K** Legally Blind.
- L** Visual Acuity: No better than 20/200 after correction in best eye, or visual field is contracted to 10 degrees or less from point of fixation or subtends to angle no greater than 20 degrees.

**MENTAL IMPAIRMENTS**

- M** Mental/Emotional: Individual with a mental or emotional impairment listed in *Diagnostic and Statistical Manual IV* of the American Psychiatric Association, the severity of which meets or exceeds standards outlined in the *Disability Evaluation Under Social Security Publication*. Disability must have been present for at least 3 months and be expected to continue for at least 3 months past the application date.
- N** Autism: Syndrome consisting of withdrawal, inadequate social relationships, language disturbance and monotonously repetitive motor behavior.

**HEARING IMPAIRMENTS**

- O** Total deafness.
- P** Persons whose hearing loss is 70 dba or greater in the 1000 and 2000 Hz ranges.