Milwaukee County Transit System
Growing Opportunities Pass Program

Dear GO Pass Applicant:

Thank you for your interest in the Growing Opportunities (GO) Pass.

This program offers an unlimited use bus pass to qualified individuals. There are four ways MCTS can confirm your eligibility:

1. Present a government issued picture ID card that includes age (65 and over) and proves residency in Milwaukee County.

2. Present a copy of a Medicare card and a government issued picture ID that proves residency in Milwaukee County.

3. Present a doctor's statement describing the nature of your disability on professional letterhead or prescription form AND present a government issued picture ID card that proves residency in Milwaukee County.

4. Present an existing MCTS issued Half-fare card and proof of residency in Milwaukee County.

The application process:

• Complete and sign the first page of the application.

• If you are applying under the requirement of option 3 above, you must have your treating physician or a Wisconsin Medical Licensed health care provider complete and sign the second page of the application along with a brief confirmation of your disability on letterhead or prescription form.

• Bring your completed application and all required documents and identification to our office located at 1942 N. 17th Street, Milwaukee, WI 53205, between the hours of 9am and 2pm, Monday thru Friday, to have your photograph taken and to receive your GO Pass.

Note: For a limited time, MCTS will be offering alternative community locations to complete the GO Pass application process and to receive your GO Pass on site. To see a full schedule and locations, please visit RideMCTS.com or call (414)343-1700.

Please complete your application carefully and understand that the following issues will negate your application:

• Inaccurate, incomplete or fraudulent information on the application.

• Lack of medical verification from either treating physician or a Wisconsin Medical Licensed health care provider (if applicable).

• Failure to provide required photo identification.

• Failure to provide proof of Milwaukee County residency. (If you do not have a government issued ID that can serve as your proof of address, please contact MCTS to discuss other acceptable options.)

There is no cost to the applicant for the initial GO Pass card, however if the card is lost or stolen, a replacement card will be issued at a cost of $10.00. Your GO Pass is to be used exclusively by you. Allowing others to use it is prohibited, and will result in the immediate loss of eligibility and blocking of the GO Pass.

For any questions or concerns regarding the GO Pass Program, please call the Milwaukee County Transit System at (414)343-1700.

Milwaukee County Transit System
GO Pass Program Application

For Office Use Only

Card Issued (date)_____ Card Renewal (date) _____ Card # _____

Comments _____ Staff Initials_____

FRONT AND BACK OF APPLICATION MUST BE COMPLETED TO PROCESS

Last Name First Name Middle Initial

Street Address Apt. # / Lot #

City State Zip Code Area Code + Phone Number

___/___/_____

Month Day Year of Birth Social Security Number

_____ I am age 65 or over and I have photo ID proof of age and residency.

_____ I am currently covered under Medicare and I have a valid Medicare card and photo ID proof of residency.

_____I have a physical or mental impairment, which meets the FTA definition (609.3) of a person with a disability, as listed below and I have photo ID proof of residency.

_____ I currently qualify for Milwaukee County Transit System's Reduced-Fare program and I have a valid MCTS Reduced Fare Photo ID card and proof of residency.

Persons with disabilities are defined by FTA as persons *"who by reason of illness, injury, age, congenital malfunction, or other incapacity or temporary or permanent disability (including any individual who is a wheelchair user or has semi-ambulatory capabilities), cannot use effectively, without special facilities, planning, or design, mass transportation service or a mass transportation facility."*
"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". Major life activities include, but are not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning, and work.

I certify that, to the best of my knowledge, the information given on this application is true and accurate. I understand that MCTS will rely upon this information when determining eligibility for the GO Pass Program. I understand that providing false or misleading information will result in my eligibility being revoked. Allowing individuals, other than myself, to utilize this card will also result in revocation.

I hereby authorize the release, either verbally or in writing, of any disability-related medical information to MCTS. I understand that this information may be used in conjunction with this application when determining my eligibility for the GO Pass Program through MCTS, and will not be released without my written authorization.

Applicant Signature _____ Date _____

Applicant must provide photo ID

MUST BE COMPLETED BY TREATING PHYSICIAN OR WISCONSIN LICENSED HEALTH CARE PROVIDER

To qualify for an MCTS GO Pass, your patient (listed on previous page) must have a physical or mental impairment that falls within the eligibility criteria listed below. Certain conditions do not qualify, i.e., pregnancy, obesity, drug/alcohol addiction, controlled epilepsy. **This form must be accompanied by a brief description of the patient's condition on official letterhead or a prescription form.**

Please check all that apply.

Is the impairment permanent? ☐ Yes ☐ No **If no, duration of impairment** _____

A. Non-Ambulatory:

☐ 1. Impairment which requires individual to use a wheelchair or similar mobility device.

B. Semi-Ambulatory:

☐ 1. **Arthritis -** American Rheumatism Assoc. may be used as a guideline for the determination of disability; Therapeutic Grade III, Functional Class III, Anatomical State III, or worse is evidence of arthritic disability.

☐ 2. **Loss of Extremities -** Anatomical deformity of or amputation of hand(s) and/or feet, or loss of major function.

☐ 3. **Cerebrovascular Accident -** Ongoing debilitating effects following occurrence of CVA, or effects of Cerebral Palsy.

☐ 4. **Cardio-pulmonary -** Serious loss of heart or lung reserves as shown by X-ray, EKG or other tests and in spite of medical treatment, there is breathlessness, pain or fatigue.

☐ 5. **Dialysis -** Individual who must use a kidney dialysis machine to sustain life.

☐ 6. **Other** _____
(Diagnosis)

How does this affect mobility? _____

_____

_____

C. Visual Impairment:

☐ 1. **Legally Blind -** Visual impairment that is bilateral and **not** correctable with lenses.

☐ 2. **Contraction of Visual Field -** Persons whose widest diameter of visual field subtends an angular distance of 20 degrees, or less than 10 degrees from point of fixation, or whose visual field efficiency is 20 degrees or less.

D. Hearing Impairment:

☐ 1. **Legally Deaf -** Hearing impairment that is bilateral and **not** correctable by hearing aid.

E. Cognitive Impairment:

☐ 1. **Developmentally Disabled -** Cognitive disability that originates before 18.

☐ 2. **Adult Mental Retardation**

☐ 3. **Autism -** Monotonously repetitive motor behavior with severe withdrawal, inappropriate response to stimuli, or very inadequate social relationships.

☐ 4. **Schizophrenia**

☐ 5. **Organic Brain Syndrome/Bi-Polar -** Cognitive disturbances that require boarding or home care, funded work activity or workshop.

F. Neurological Disabilities:

☐ 1. **Cerebral Palsy -** Impairment not controlled with medication.

☐ 2. **Multiple Sclerosis -** Impairment not controlled with medication.

☐ 3. **Epilepsy -** Grand Mal or Psychomotor; Persons who are seizure-free for period of **six** months do not qualify.

____Applicant's Impairment DOES NOT MEET any of the functional limitations listed above. Therefore, I cannot certify that the applicant's impairment meets the eligibility criteria for receiving an MCTS GO Pass.

Please Print: All information in this box MUST be provided by treating physician or licensed health care provider (WI Med Lic).

Physician's / Health Care Provider's Name — State License Number (Required)

Office Address — City — State — Zip Code

Area Code + Phone Number — Area Code + Fax Number

I certify that the applicant (listed on reverse side) is disabled as defined by the above criteria, and that the information I have provided is true and correct. I am currently treating the applicant for the disability(s) indicated above.

Authorized Signature — **Date**