

APPLICATION

Please complete in full:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____

Emergency Contact Person: _____

Relationship to Applicant: _____

Emergency Phone Number: _____

**I am applying for a Special Citizen I.D. Card on the following basis:
(Please check only one)**

- I am providing proof of eligibility and am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability.
- I am 60 years of age or older.
- I am providing proof of current eligibility by the Veterans Administration as having a disability.
- I am presenting a valid Medicare card issued by the Social Security Administration.
- I am providing a valid Special Citizen I.D. Card issued by _____

- I have an apparent impairment meeting one or more of the medical criteria listed in the *Definitions of Disabilities* section.
- I am medically disabled as certified by a Physician, Psychiatrist, Psychologist (Ph.D.), Audiologist, or other qualified professional licensed in the State of Oregon. SAMTD reserves the right to contact your Health Care Provider for verification.

Applicant's Signature _____ Date _____

DEFINITIONS OF DISABILITIES

Indicate the disability that keeps this applicant from using Cherriots buses as effectively as someone without such limitations:

1. Wheelchair/Non-Ambulatory: requires use of wheelchair or three-wheeler for transportation that prevents independent mobility.
2. Restricted Mobility/Semi-Ambulatory: causes difficulty walking and requiring use of mobility aid (such as a cane or walker), and prevents independent mobility.
3. Arthritis: causes a functional motor defect in any two major limbs, and prevents independent mobility.
4. Loss of Extremities: with loss of major function that prevents independent mobility.
5. Head injury: with functional motor defect that prevents independent mobility.
6. Respiratory Impairment (dyspnea): occurs during activities such as climbing one flight of stairs, walking 200 yards on the level, or less exertion, or even at rest.
7. Cardiac Disease: results in marked limitation of physical activity.
8. Disorders of the Spine: fractures with motor and sensory loss, osteoporosis with pain and limitation of movement, that prevents independent mobility.
9. Nerve Root Compression Syndrome: with pain and motion limitation in back of neck that prevents independent mobility
10. Motor Impairment: due to faulty coordination or palsy from brain, spinal, or peripheral nerve injury that prevents independent mobility.
11. Visual Impairment: that prevents independent mobility.
12. Hearing Impairment: that prevents independent mobility.
13. Development Disabilities: that prevents independent mobility.
14. Autism: that prevents independent mobility.
15. Neurological Impairment: caused by cerebral palsy, muscular dystrophy, multiple sclerosis, seizure disorder, or other neurological impairments not controlled by medication, and prevents independent mobility.
16. Mental Impairment: to the degree that independent mobility is prevented
17. Other _____

TO BE COMPLETED BY THE CERTIFYING AGENT:

I certify that _____, can be defined as disabled
(Print Name of Applicant)
according to the Federal Transit Administration's definition of disabled (as noted on page 1).

I have marked the appropriate section(s) on Page and believe this applicant should be certified _____ eligible.
(either *Temporarily/Permanently)

*Length of temporary disability is estimated to be _____
(Numbers of Months)

COMMENTS regarding applicant's disability:

*

Certifying Agent/Physician Name: _____

Agency Name & Address/Physician's Address: _____

Agency Phone Number/Physician's Phone Number: _____

Are you a licensed Physician? YES NO

(Signature of Certifying Agent/Physician)

(Date)

For more information, call SAMTD Customer Service at 503-588-2877.
Spanish translations can be requested.

**Return completed form IN PERSON to:
Salem Area Mass Transit District
555 Court St NE Ste. 5230
Salem OR 97301-3736**