

REDDING AREA BUS AUTHORITY

Disabled Identification Card

for the

Fixed Route System

What is it?

The RABA Disabled Identification Card simplifies travel for disabled riders of public transportation on RABA's fixed route system.

Who is eligible?

Any person who presents proof of one or more of the following conditions can obtain a RABA Disabled Identification Card:

1. Is now eligible for Social Security Disability Benefits or now receives Supplemental Security Income Benefits because of disability.
2. Is currently certified by the Veterans Administration at a 40 percent or greater disability level.
3. Has a valid MediCARE card issued by the Social Security Administration.
4. Has a valid ADA paratransit card from outside the region (temporary).
5. Has obvious physical impairments meeting one or more of the medical criteria on reverse.
6. Is certified by a California State-licensed physician (M.D.), psychiatrist, psychologist (Ph.D.) or audiologist (certified by the American Speech and Hearing Association) as meeting one or more of the medical criteria on reverse.

Where can I Apply?

Any eligible person may apply for a RABA Disabled Identification Card by mail or in person at 3333 So Market Street between the hours of 8:00 a.m. and 5:00 p.m., Monday - Friday. If you are applying by mail, your card will be mailed to you.

How long is it valid?

Identification cards issued to persons permanently disabled will be valid for a three year period at which time the card must be renewed. Persons with disabilities that will last between three months and one year may receive temporary permits. These permits, which carry an expiration date, maybe renewed only if the disability continues beyond that date. RABA retains the right to ask for recertification upon loss of a permit or at any other time.

What does it cost?

There is no charge for the RABA Disabled Identification Card.

How does it work?

The identification card is used as proof of eligibility to pay a reduced fare. The permit has no cash value and may not be used as a transfer between systems. **The permit holder must pay the amount of the reduced fare, and use of the permit is subject to any restrictions in effect by RABA.**

Questions?

If you have comments or questions regarding the RABA Disabled Identification Card, please call 530-245-7089.

This agency reserves the right to contact your Health Care Provider for verification.

MEDICAL ELIGIBILITY CRITERIA AND CONDITIONS

SECTION 1. NON-AMBULATORY DISABILITIES

1. **Wheelchair-User.** Impairments which, regardless of cause, confine individuals to wheelchairs.

SECTION 2. SEMI-AMBULATORY PHYSICAL DISABILITIES

1. **Restricted Mobility.** Impairments which cause individuals to walk with difficulty including, but not limited to, individuals using a long leg brace, a walker or crutches to achieve mobility, or birth defects and other muscular/skeletal disabilities, including dwarfism, causing mobility restriction.
2. **Arthritis.** Persons who suffer from arthritis causing a functional motor defect in any two major limbs. (American Rheumatism Association criteria may be used as a guideline for the determination of arthritic handicap: Therapeutic Grade III. Functional Class III, or Anatomical State III or worse is evidence of arthritic handicap.)
3. **Loss of Extremities.** Persons who suffer anatomical deformity of or amputation of both hands, one hand and one foot, or lower extremity at or above the tarsal region. Loss of major function may be due to degenerative changes associated with vascular or neurological deficiencies, traumatic loss of muscle mass or tendons, bony or fibrous ankylosis at unfavorable angle, or joint subluxation or instability.
4. **Cerebrovascular Accident.** Persons displaying one of the following, four months post-CVA:
 - a. Pseudobulbar palsy; or
 - b. Functional motor defect in any of two extremities; or
 - c. Ataxia affecting two extremities substantiated by appropriate cerebellar signs or proprioceptive loss.
5. **Respiratory.** Persons suffering respiratory impairment (dyspnea) of Class 3 or greater as defined by "Guides to the Evaluation of Permanent Impairment: The Respiratory System," Journal of the American Medical Association, 194:919 (1965).
6. **Cardiac.** Persons suffering functional classifications III or IV and therapeutic classifications C, D, or E cardiac disease as defined by Diseases of the Heart and Blood Vessels - Nomenclature and Criteria for Diagnosis, New York Heart Association (6th Edition).
7. **Dialysis.** Persons who must use a kidney dialysis machine in order to live.
8. **Disorders of Spine.** Persons disabled by one or more of the following:
 - a. Fracture of vertebra, residuals or, with cord involvement with appropriate motor and sensory loss; or
 - b. Generalized osteoporosis with pain, limitation of back motion, paravertebral muscle spasms, and compression fracture of vertebra; or
 - c. Ankylosis or fixation of cervical or dorsolumbar spine at 30 degrees or more of flexion measured from the neutral position and one of the following:
 - 1) Calcification of the anterior and lateral ligaments as shown by x-ray; or
 - 2) Dilateral ankylosis of sacroiliac joints and abnormal apophyseal articulation as shown by x-ray.
9. **Nerve Root Compression Syndrome.** A person disabled due to any cause by:
 - a. Pain and motion limitation in back of neck; and
 - b. Cervical or lumbar nerve root compression as evidenced by appropriate radicular distribution of sensory, motor and reflex abnormalities.
10. **Motor.** Persons disabled by one or more of the following:
 - a. Faulty coordination or palsy from brain, spinal or peripheral nerve injury; or
 - b. A functional motor deficit in any two limbs; or
 - c. Manifestations significantly reducing mobility, coordination and perceptiveness not accounted for in prior categories.
11. **HIV Disease.** A person disabled by HIV disease who meets Social Security eligibility criteria or who meets California State medical criteria.

SECTION 3. VISUAL DISABILITIES

1. Persons disabled because of:
 - a. Visual acuity of 20/200 or less in the better eye with correcting lenses; or
 - b. Contraction of visual field:
 - 1) So the widest diameter of visual field subtending an angular distance is no greater than 20 degrees; or

- 2) To 10 degrees or less from the point fixation; or
 - 3) To 20 percent or less visual field efficiency.
2. Persons who, by reason of a visual impairment, do not qualify for a Driver's License under regulations of the California State Department of Motor Vehicles.

SECTION 4. HEARING DISABILITIES

1. Persons disabled because of hearing impairments manifested by one or more of the following:
 - a. Better ear pure tone average of 90 dB HL (unaided) for tones at 500, 1000, 2000, Hz; or
 - b. Best speech discrimination score at or below 40% (unaided) as measured with standardized testing materials.
2. Eligibility may be certified by a physician licensed by the State of California or by an audiologist certified by the American Speech, Language, Hearing Association.

SECTION 5. NEUROLOGICAL DISABILITIES

1. **Epilepsy**
 - a. Persons disabled by reason of:
 - 1) A clinical disorder involving impairment of consciousness, characterized by uncontrolled seizures (grand mal or psychomotor) substantiated by EEG occurring more frequently than once per week in spite of prescribed treatment with:
 - a) Diurnal episodes (loss of consciousness and convulsive seizure); or
 - b) Nocturnal episodes which show residuals interfering with activity during the day; or
 - c) A disorder involving petit mal or mild psychomotor seizures substantiated by EEG occurring more frequently than once per week in spite of prescribed treatment with:
 - i. Alteration of awareness or loss of consciousness; and
 - ii. Transient postictal manifestations of conventional or antisocial behavior.
 - b. Persons exhibiting seizure-free control for a continuous period of more than six (6) months duration are not included in the statement of epilepsy defined in this section.
2. **Neurological Handicap.** A person disabled by cerebral palsy, multiple sclerosis, muscular dystrophy, or other neurological and physical impairments not controlled by medication.

SECTION 6. MENTAL DISABILITIES

1. **Developmental Disabilities.** A person disabled due to mental retardation or other conditions found to be closely related to mental retardation or to require treatment similar to that required by mentally retarded individuals and:
 - a. The disability originates before such individual attains age 18,
 - b. Has continued, or can be expected to continue, indefinitely, and
 - c. The disability constitutes a substantial handicap to such individual.
2. **Adult Mental Retardation.** Persons who by reason of accident or illness occurring after age 18 are in a substantially similar condition to a developmentally disabled individual.
3. **Autism.** Persons disabled by reason of a syndrome described as consisting of withdrawal, very inadequate social relationships, language disturbances, and monotonously repetitive motor behavior appearing generally before the age of six and characterized by severe withdrawal and inappropriate response to extended stimuli.
4. **Mentally Disordered Disabilities (Emotionally Disturbed).** **TEMPORARY PERMITS ONLY.** Those persons diagnosed as substantially disabled by mental disturbances who meet at least one of the following criteria:
 - a. Are living in a board and care home and receiving state or federal financial assistance and participate in a state or federally funded work activity center or workshop.
 - b. Are living at home under supervision and participation in a state or federally funded state or federal work activity center or workshop.
 - c. Are participating in any training or rehabilitation program established under federal, state, county or city governmental agencies.

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APPLICATION

Card# _____

Date Processed _____

Expiration Date _____

PLEASE TYPE OR PRINT (The information requested is confidential; any release of this data is for transit planning purposes only, and your name will not be used.)

Name _____ SSN# _____
First Middle Last

Street Address _____
Street City State Zip

Mailing Address _____
Street/PO Box City State Zip

Date of Birth _____ Phone No. _____

Please read the applicant section of the *Medical Eligibility Criteria and Conditions* flyer before completing this application.

I am applying for a Disabled Identification 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 providing proof of current eligibility by the Veterans Administration as having a disability of at least 40%.
- I am presenting a valid Medicare card issued by the Social Security Administration.
- I am providing a valid ADA paratransit card from outside the region.
(For issuance of a Temporary Disabled Identification Card.)
- I have an obvious physical impairment(s) meeting one or more of the medical criteria listed in the *Medical Eligibility Criteria and Conditions* flyer.
- I am medically disabled as certified by a Physician (M.D.), Psychiatrist, Psychologist (Ph.D.), or Audiologist, licensed in the state of California. **See Health Care Providers Certification form on the reverse side of this application.** This agency reserves the right to contact your Health Care Provider for verification.

Applicant's Signature _____ Date _____

RABA Disabled Identification Card - Certification of Eligibility

Applicant's Release

I hereby authorize the physician to release any information necessary to complete this certification. I understand that this information is confidential and shall not be released without my approval or a court order. I understand that the transit agency issuing this permit shall have the right and opportunity to verify my eligibility for a RABA Disabled Identification Card. I understand that if any of the statements made on this application form are false or inaccurate, I will lose the privileges granted by the Reduced Fare Permit and be subject to criminal prosecution in accordance with California State law.

Please Print

Name _____ Phone No. _____
First Middle Last

Street Address _____
Street City State Zip

Applicant's Signature _____ Date _____

This Section To Be Completed By The Following Approved Health Care Provider:

California State-licensed: • Physician (M.D.) • Psychiatrist • Psychologist (Ph.D.)
• Audiologist certified by the American Speech, Language and Hearing Association

Signatures of Health Care Providers other than those above are not acceptable.

Instructions:

1. This applicant must meet at least one of the criteria and conditions listed in the Medical Eligibility Criteria flyer. (attached)
2. The specific Medical Eligibility Criteria number must be noted in the space provided.
3. If Section 6.4 (emotionally disturbed) is used, this person must be diagnosed by you as being "Substantially Disabled." The appropriate subsection (a, b or c) must be included along with the name and phone number of the work activity center, training or rehabilitation program in which this patient is currently a patient.
Note: An applicant's enrollment in a drug or alcohol rehabilitation program does not, in and of itself, meet eligibility requirements.
4. An applicant's financial situation has no bearing of eligibility.

This section is to be completely filled out by the approved Health Care Provider.

I certify that _____ meets the Medical Eligibility Criteria _____.
(Applicant) (Section Number)

If Section 6.4 (a, b or c is used) enter name of qualifying program: _____

Please check the appropriate boxes:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | The disability is Temporary . Specify length of disability: _____ months. A temporary disability must be expected to last at least three months, but no longer than one year. |
| <input type="checkbox"/> | <input type="checkbox"/> | The disability is Permanent . |
| <input type="checkbox"/> | <input type="checkbox"/> | This applicant requires a Personal Care Attendant (if yes: <input type="checkbox"/> temporary <input type="checkbox"/> permanent) |

Verification of Approved Health Care Provider

Please Print

Name _____ Phone No. _____

Provider or Agency Address _____

Signature _____ Date _____

I understand that if any of the statements made on this application form are false or inaccurate, I will be subject to criminal prosecution in accordance with California State Law.