

# Transportation Access Pass (TAP) CharlieCard Application

## What are you currently applying for? (select one)

Apply for a Transportation Access Pass (TAP) / CharlieCard for Persons with Disabilities

Renew my current / expired Transportation Access Pass (TAP). **You do not need to continue this application.**

Replace my missing or damaged Transportation Access Pass (TAP). **You do not need to continue this application**

## Before You Begin

**Remember: This application is meant for people with disabilities who are applying for the first time.** To complete this application, you will need:

**1. A government-issued photo ID**

You may upload a driver's license, a passport, or another government-issued photo ID. Expired IDs will not be accepted.

**2. A recent color photo of yourself**

Your photo must be from the neck up, in front of a solid and light colored background. You cannot be wearing a hat, face covering, or sunglasses. Religious head coverings and glasses without a visible glare are acceptable within the photograph.

### 3. Documentation of a disability

Unless you are replacing your TAP CharlieCard, you will need to show documentation of a disability. You will have three options for this, **you only need to select one of the options below:**

A. Option 1: Upload proof of disability through one of the options below:

Medicare, One Care, or Tufts Health Unify Card

Disability placard from the Registry of Motor Vehicles (RMV)

Signed letter from your Travel Trainer on MBTA letterhead

Veteran benefits summary letter on VA letterhead specifying a disability rating of 70% or greater

Current non-MBTA reduced fare card with an expiration date

Verification letter signed by case manager or coordinator from one of the following agencies:

Department of Mental Health (DMH), including DMH vendors

Department of Developmental Services (DDS)

Massachusetts Rehabilitation Commission (MRC)

B. Option 2: Enter an active RIDE ID number

C. Option 3: Upload the Health Care Professional Certification form signed by a health care provider. The form for your provider is placed at the end of this application. **You only need to fill out this form if you have selected Option 3 to provide documentation of your disability.**

## 4. Personal Information

Date of birth (required):

First name (required):

Last name (required):

Address Line 1 (Required): \_\_\_\_\_

Address Line 2 (Required): \_\_\_\_\_

City (Required): \_\_\_\_\_

State(Required): \_\_\_\_\_

Zip / Postal Code (Required): \_\_\_\_\_

## 5. Contact Information (Optional)

This information will only be used to contact you regarding your application. We will send you updates about the status of your application as needed.

Phone number (optional):

Email (optional):

## 6. Emergency Contact (Optional)

Emergency contact name:

Emergency contact relationship:

Emergency contact phone number:

## 7. Getting Your Card

Please select how you would like to receive your Transportation Access Pass (TAP) CharlieCard if your application meets the criteria and is approved.

I will pick up the card at the designated LRTA facility at 113 Thomdike St.  
Lowell, MA 01852

Mail the card to my address

## Health Care Professional Certification

This form is **only** required when the applicant has selected Option 3 as their way to provide evidence of their disability for their Transportation Access Pass (TAP) CharlieCard. This form must be completed by a licensed or certified health care professional, and must be received by the LRTA within 60 days of the health care provider's signature. If printing and filling in this form, please write in clear printed handwriting.

**Name of Healthcare Professional:** \_\_\_\_\_

**Licensure Title:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**License Number:** \_\_\_\_\_ **State Issued:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**IMPORTANT PROGRAM NOTE:** The LRTA issues the Transportation Access Pass CharlieCard based on the level of difficulty experienced by the applicant, and the extra planning and effort that may be required, to use public buses/trains/subway due to a physical, psychiatric, intellectual, or sensory disability. The TAP CharlieCard is issued to applicants with disabilities who find it moderately / severely difficult to wait for a bus, hear announcements, read visual signs, understand and / or follow directions, board the correct train, maintain stamina, function well in crowds, walk certain distances to transfer between transit modes, etc. The TAP CharlieCard **IS NOT ISSUED** based on an applicant's income level.

1. What is the applicant's disability?

Use *Guideline Number(s)* from back page: \_\_\_\_\_

Specific Diagnosis: (Must be completed by the Health Care Professional)

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

2. How does the disability cause the applicant difficult, as described in "Important Program Note" section above, when traveling on the LRTA? Please specify: (Must be completed by the Health Care Professional)

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

3. Expected duration of disability: Please select only one of the two options below:

\_\_\_\_\_ Conditions with potential for improvement within 1 year

\_\_\_\_\_ Conditions with no expectation of improvement

4. I certify that the information I have provided above about this LRTA TAP CharlieCard applicant is correct to the best of my knowledge:

\_\_\_\_\_  
**Signature of Health Care Professional**

\_\_\_\_\_  
**Date**

# Guidelines for Health Care Professionals

Please use the categories below to complete **Part C Health Care Professional Certification, Item #1: "What is applicant's disability?"**

|   |  |
|---|--|
| <p><b>1. WHEELED MOBILITY DEVICE USERS:</b> Those who, due to a disability, require the use of wheeled mobility, e.g. wheelchair, scooter, etc.</p>   | <p><b>2. SEMI-AMBULATORY DISABILITIES:</b> Those who, due to a disability, walk with difficulty or insecurity and may or may not use leg braces, walker, cane, crutches.</p>   |
| <p><b>3. SEVERE MUSCULOSKELETAL CONDITIONS</b> such as muscular dystrophy, osteogenesis imperfecta or arthritis where functional capacity is limited in ability to perform usual self care and/or vocational and avocational activities.</p>  | <p><b>4. AMPUTATION OF AN EXTREMITY.</b> Please specify which limb(s) are affected.</p>  |
| <p><b>5. SEVERE EFFECTS FROM CVA (STROKE):</b> Eligible conditions include functional motor deficit affecting any two limbs or ataxia 4 months post cva.</p>  | <p><b>6. SEVERE PULMONARY CONDITIONS</b> (obstructions/restrictions) that affect mobility. Those with PFT outcomes &lt; 50% of predicted values (FEV1; FVC; %FEV1; FEF25%-75%). Dyspnea occurs during usual activities of daily living; climbing a flight of stairs or walking 100 yards; with the slightest exertion; or even at rest.</p>  |
| <p><b>7. SEVERE CARDIAC CONDITIONS</b> that result in moderate or marked restriction in ordinary physical activity; and may cause fatigue, palpitations, dyspnea or angina pain when walking one or more level blocks, climbing a flight of ordinary stairs, or even at rest. Classifications: Functional III or IV; Therapeutic C or D.</p>  | <p><b>8. PERSONS REQUIRING KIDNEY DIALYSIS TREATMENT</b></p>   |
| <p><b>10. HEARING-RELATED DISABILITIES:</b> Deafness or hearing loss of 90 db or greater in the 500, 1,000, and 2,000 HZ ranges. Please specify the degree of response in each of these ranges.</p>   | <p><b>9. VISION IMPAIRMENTS:</b> Those who are legally blind, whose visual acuity in the better eye, after correction, is 20/200 or worse or visual field is contracted. [Applicant will be eligible for <b>MBTA Blind Access CharlieCard</b> with a current MA Commission for the Blind Card/Certificate or other Blindness Certification]</p>  |
| <p><b>12. INTELLECTUAL DISABILITY:</b> Those with I.Q. more than two standard deviations below the norm. Please specify I.Q.</p>  | <p><b>11. COORDINATION DISABILITIES:</b> Those with a functional motor deficit in any two limbs or who experience manifestations that significantly reduce mobility, coordination and/or perception.</p>   |
| <p><b>14. EPILEPSY (CONVULSIVE DISORDER):</b> Please include severity and frequency of seizure activity despite medication.</p>   | <p><b>13. CEREBRAL PALSY:</b> Please include extent of difficulty in motor function.</p>   |
| <p><b>16. NEUROLOGICAL DISABILITIES</b> affecting learning, perceptual and behavioral functioning. Please include nature of condition and etiology.</p>   | <p><b>15. AUTISM:</b> Please describe nature and severity of disability.</p>   |
| <p><b>18. PROGRESSIVE ILLNESSES</b> that impact the performance of the applicant's organic system so the symptoms produced fall within categories 1 – 17 above.</p> <p>Please indicate applicable categories above that best describe impact of illness on applicant's functional ability to use public transit buses, subway and trains.</p> | <p><b>17. PSYCHIATRIC DISABILITIES:</b> This section applies to those who have a <b>serious, long-term mental illness</b>, that:</p> <ul style="list-style-type: none"> <li>• includes a substantial disorder of thought, memory, perception, or orientation</li> <li>• grossly impairs judgment, behavior, capacity to recognize reality, or</li> <li>• greatly impacts ability to meet ordinary/independent life support needs of food, shelter, clothing, management of finances, and health care.</li> </ul> <p>Please indicate description and duration of condition.</p> |

**For Internal Use Only:** Staff initials \_\_\_\_\_ Date \_\_\_\_\_

Approved: \_\_\_\_\_ Auto Renew \_\_\_\_\_ Denied \_\_\_\_\_ Incomplete \_\_\_\_\_