



**This Section to Be Completed by an Approved Health Care Provider:**

**Georgia State Licensed:** Physician (M.D.)~ Psychiatrist~Psychologist (Ph.D.)~Audiologist certified by the American Speech, Language and Hearing Association~Physician's Assistant (P.A.)~Advanced Registered Nurse Practitioner (A.R.N.P.)~Optometrist

**Signatures of Health Care Providers other than these are not acceptable.**

1. The applicant must meet at least one of the criteria and conditions listed on the **Eligibility Guidelines** page for Reduced Fare. **(Page 3)**
2. The specific category number and type **(See Page 3)** must be noted in the space provided.
3. The applicant's enrollment in a drug or alcohol rehabilitation program **DOES NOT**, in and of itself, meet program eligibility requirements.
4. The applicant's financial situation has **NO** bearing on eligibility.

**Please select the appropriate disability category from the Eligibility Guidelines page and notate in the space provided below.**

**Category #**   if category # is 5,6,10,11 or 12 please give a specific diagnosis: \_\_\_\_\_

**Category Type:** \_\_\_\_\_ **Condition (Check One):** Temp  Perm

If disability is temporary, please specify length of disability: \_\_\_\_\_ Months.

**Certification by an Approved Health Care Facility / Provider (Please Print)**

**Name of Health Care Facility:** \_\_\_\_\_

**Name of Provider:** \_\_\_\_\_ **Phone No:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_

**Georgia State License No:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Provider** **Date**

I certify that the above named individual meets the Eligibility Criteria that is listed in the guidelines for MARTA'S Reduced Fare Program (page 3). I understand that if any statements on this application form are false or inaccurate, I will be subject to criminal prosecution in accordance with Georgia State Law for fraud (O.C.G.A. 16-10-20)

**For Official MARTA Use Only**

**Approved**

**Denied**  **Reason for Denial:** \_\_\_\_\_

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

# Eligibility Guidelines for the MARTA Reduced Fare Program

---

Note: These guidelines are not intended to be inclusive of all disability types. However, the following categories and descriptions are provided to the health care provider as examples of generally accepted guidelines within the transit industry in interpretation of the Federal Transit Administration's (FTA) definition of disabilities for persons seeking to participate in a transit agency's half fare program.

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." 49 CFR Ch. VI (10-1-12 Edition) Pt 609, APP A

## PLEASE SELECT ONE OF THE FOLLOWING CATEGORIES:

### 1 NON-AMBULATORY:

An individual is unable to walk and requires the use of a wheelchair or other mobility device

### 2 SEMI-AMBULATORY:

An individual has a chronic condition which substantially limits the ability to walk, or is unable to walk without the use of a caliper leg brace, walker or crutches.

### 3 AMPUTATION:

An individual has an amputation of one or both hands, arms, feet or legs

### 4 STROKE:

An individual has substantial functional motor deficits in any of two extremities, loss of balance and/or cognitive impairments three months post stroke.

### 5 NEUROLOGICAL CONDITIONS OTHER THAN STROKE:

An individual has difficulty with coordination, communication, social interaction and/or perception from a brain, spinal or peripheral nerve injury or illness, has functional motor deficits, or suffers manifestations that significantly reduce mobility.

### 6 PULMONARY OR CARDIAC CONDITIONS:

An individual has a pulmonary or cardiac condition resulting in marked limitation of physical functioning and dyspnea during activities such as climbing steps and/or walking a short distance. If diagnosis is asthma, please state whether: a) individual has been on systemic medication for the immediate past six months. OT b) individual has been required to use fast acting inhaler for three or more episodes per week for immediate past six months.

### 7 VISUALLY IMPAIRED:

An individual is legally blind, whose visual acuity in the better eye, with correction, is 20/200 or less, or who has tunnel vision to 10 degrees or less from a point of fixation or so the widest diameter subtends an angle no greater than 20 degrees. An individual has low vision, and whose visual acuity is in the range of 20/70 to 20/200 with best correction.

### 8 DEAF OR HARD OF HEARING:

An individual with a pure tone average greater than 70 dB in both ears, regardless of use of hearing aids.

### 9 EPILEPSY:

An individual has had at least one tonic-clinic seizure with the past four months.

### 10 DEVELOPMENTAL OR LEARNING DISABILITIES:

An individual has a significant learning, perceptual and/or cognitive disability. Some conditions are excluded from eligibility such as attention deficit disorder (ADD) and ADHD.

### 11 MENTAL ILLNESS:

An individual whose mental illness includes a substantial disorder of thought, perception, orientation, or memory that impairs judgement and behavior.

### 12 CHRONIC PROGRESSIVE DEBILITATING CONDITIONS:

An individual who experiences debilitating diseases, autoimmune deficiencies or progressive and uncontrollable malignancies. Any of which are characterized by fatigue, weakness, pain and/or changes in mental status that impair mobility.