Handi-Card Eligibility Application

Please mail, email or fax your completed application to:

Michiana Area Council of Governments (MACOG)
227 W. Jefferson Blvd.
1120 County-City Building
South Bend, IN 46601

Phone: (574) 674-8894
Fax: (574) 239-4072
E-mail: macogdir@macog.com

Revised 12/14/2016

Overview

MACOG offers half-fares during non-peak hours on the Interurban fixed route service to qualifying persons with physical or cognitive disabilities, along with persons 65 years and older.

Non-Peak Hours are:

- Before 7:00 AM
- 11:00 AM to 3:00 PM
- After 6:00 PM.

It is important to complete all parts of this form; incomplete applications will be returned. All information will be kept confidential.

Please note: if you have a **MEDICARE** card, you may use your card as identification for reduced fares; a HANDI-CARD is not needed.

MEDICAID cards, social security and MEDICARE disability checks are not valid for reduced fares.

A picture ID will be also be required.

Appeal Process

Persons whose application is not found eligible may appeal the decision in writing, within 60 days of the date of their determination letter. Send appeals to:

Michiana Area Council of Governments (MACOG)
227 W. Jefferson Blvd.
1120 County-City Building
South Bend, IN 46601

The Elkhart/Goshen Transit Advisory Committee will review the eligibility documentation and make a final decision on eligibility status. This review will be concluded within twenty-one working days of the date the appeal was received. The person making the appeal has the right to appear at this review.

PART B – Handi-Card Eligibility Application

Please Print:

Last Name First Name Middle Name

Home Address:

Address

City Zip Code

Mailing Address (If different from Home Address):

Address

City Zip Code

Contact Information:

Daytime Phone Evening Phone Cell Phone

Fax Email

Personal Information:

☐ Male ☐ Female Date of Birth: ____/____/____
MM DD YYYY

Do you have a Medicare Card

☐ Yes ☐ No

If YES - you may use your Medicare Card for reduced fares. No Handi-Card is needed.

PART B – Handi-Card Eligibility Application

1. What is the nature of your disability or health condition? (Be Specific)
   _____
   _____
   _____
   _____
   _____

2. Is your disability considered permanent? ☐YES ☐No

3. If no, how long do you expect to have this disability? _____
   _____

4. Designate any mobility aids you use (check all that apply)
   - ☐ Manual Wheelchair
   - ☐ Service Animal
   - ☐ Prosthesis
   - ☐ Cane
   - ☐ Portable Oxygen
   - ☐ Leg Braces
   - ☐ Motorized Wheelchair
   - ☐ White Cane
   - ☐ Crutches
   - ☐ Powered Scooter
   - ☐ Walker
   - ☐ Other_____

PLEASE READ THE FOLLOWING STATEMENTS AND CHECK THOSE THAT BEST DESCRIBE WHAT YOU BELIEVE IS YOUR ABILITY TO USE THE TROLLEY SYSTEM. YOU MAY SELECT MORE THAN ONE.

- ☐ I use the trolley service frequently.
- ☐ I can use the trolley sometimes, if the conditions are right.
- ☐ I have difficulty understanding and/or remembering all of the things I need to do to find my way to and from the route.
- ☐ I have a temporary disability, which prevents me from getting to the designated stop.
- ☐ I believe I could learn to ride the trolley system, if someone would teach me.

PART B – Handi-Card Eligibility Application

- ☐ I have difficulty or cannot climb stairs and can only board a trolley with a lift or ramp.
- ☐ I have a visual disability, which prevents me from getting to and from the route.
- ☐ The severity of my disability changes from day to day. I can ride the trolley only when I am feeling well.
- ☐ I have a severe medical condition. My condition results in an impairment, which makes it impossible for me to use the trolley system.

INFORMATION ABOUT YOUR ABILITY TO USE THE TROLLEY SYSTEM

1. If you use fixed route trolley service now, do you need the assistance of another person? (Check one)
   ☐ Always ☐ Sometimes ☐ Never

2. If you need another person's assistance to aid your mobility, what does that person do for you?
   _____
   _____
   _____

3. What is it about riding a fixed route trolley that is most difficult for you? (Example: The trolley moves before I am seated, etc.) Please list as many things as you can think of. If you need additional space, please use a separate piece of paper.
   _____
   _____
   _____
   _____
   _____
   _____

Applicant Certification

I certify that I have been truthful in answering this form and that the information that I have provided is correct. I understand that the purpose of this application is to determine if I am eligible to obtain a HANDI-CARD for reduced fares. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only the information required to provide services I request will be disclosed to those who perform the services.

I understand that an eligibility determination will be made within 21 days of the date that MACOG receives my application. I understand that if my application is not found eligible, that I may appeal such determination within 60 calendar days and that I will be advised of the procedures for such an appeal.

I understand that it may be necessary to contact a professional familiar with my disabilities in order to assist in the determination of eligibility.

Applicant's signature: _____ Date: _____

Did someone help you in filling out this form? ☐ Yes ☐ No

If yes, Name: _____ Phone: _____

Relationship to Applicant: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____

Signature: _____ Date: _____

PART C - Healthcare/Social Service Professional Verification

In order for MACOG to evaluate your request, it may be necessary to contact a professional to confirm the information you have provided or to answer any additional questions about your disabilities. Please identify a person who could document your disability by completing the following information and authorization form.

The following professional is **most familiar with my disability and my functional abilities to ride public transit** :

_____

Professional's First and Last Name

_____

Address

_____

City Zip Code

_____ _____ _____

Phone Fax Email

Check the appropriate box to identify professional relationship:

- ☐ independent living specialist
- ☐ chiropractor
- ☐ mental health counselor
- ☐ nurse practitioner
- ☐ occupational or physical therapist
- ☐ ophthalmologist or optometrist
- ☐ orientation and mobility specialist
- ☐ other: _____
- ☐ physician
- ☐ physician's assistant
- ☐ psychologist or psychiatrist
- ☐ registered nurse
- ☐ rehabilitation counselor
- ☐ social worker
- ☐ vocational rehab. counselor

I authorize the release of required information to MACOG for certification.

Applicant's signature: _____ Date: _____

PART C - Healthcare/Social Service Professional Verification

FOR OFFICE USE ONLY

Eligibility Determination ☐Approved ☐Denied

ID# _____

If Denied, Reason for Ineligibility: _____

_____

_____

If Approved: Basis for Eligibility: _____

_____

_____

DATE _____

COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

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_____