Woods Hole, Martha's Vineyard and Nantucket Steamship Authority

Mashpee Reservations Department

Steamship Authority Transportation Access Pass Program

Individuals with disabilities may apply for a "Steamship Authority Transportation Access Pass" which, when approved and issued by the Authority, entitles the holder to a discounted fare upon its presentation with appropriate identification to a ticket seller.

In order to be eligible for a "Steamship Authority Transportation Access Pass," an individual must fall into one of the categories listed below for eligibility and submit the appropriate application for processing along with the required documentation.

INDIVIDUALS WHO ARE ELIGIBLE:

- Have a permanent physical disability that substantially limits one or more of the individual's major life activities affecting the individual's mobility or coordination.
- They suffer from a serious, long-term mental illness, or is a current recipient of services through the Massachusetts Department of Mental Health or the Massachusetts Department of Developmental Services.
- Is a veteran with a disability rating of seventy percent (70%) or greater.

REQUIREMENTS:

- Completed application, Signed by applicant AND Health Care Professional.

AND

- Documentation as a current recipient of services through the Massachusetts Department of Developmental Services.
- Documentation of a veteran with a disability rating of 70% or greater. Certification from the VA, signed by a Veteran's Services Officer, which specifies the individual's disability rating.

OR

- Certification from a Licensed Health Care Professional, demonstrating the applicant falls under one of the above eligibilities. Along with Part C, completed on the application.

WHO IS A LICENSED/CERTIFIED HEALTH CARE PROFESSIONAL:

Examples of licensed/certified health care professional include those who are familiar with your disability and are licensed or certified in their field, such as Medical Doctor, Licensed Social Worker, Psychologist, Audiologist, Registered Nurse or Psychiatrist.

Completed applications, signed & with all proper documentation may be sent to:

POSTAL MAIL:
Attn: Angela Campbell
Steamship Authority
509 Falmouth Road, Suite 1C
Mashpee, Mas 02649

EMAIL:
acampbell@steamshipauthority.com

or

FAX: 508-457-4518

Woods Hole, Martha's Vineyard and Nantucket Steamship Authority

Mashpee Reservations Department

STEAMSHIP AUTHORITY TRANSPORTATION ACCESS PASS APPLICATION

PART A

Applicant Information:

☐ **NEW** ☐ **REPLACEMENT CARD** ☐ **RENEWAL/EXTENSION**

NAME: DATE:

DATE OF BIRTH: HOME PHONE: CELL PHONE:

MAILING ADDRESS: CITY: STATE: ZIP CODE:

EMAIL:

Emergency Contact:

NAME: RELATIONSHIP:

MAILING ADDRESS: CITY: STATE: ZIP CODE:

EMAIL: PHONE:

PART B (check one)

☐ I am a current recipient of services through the Massachusetts Department of Developmental Services (DDS). **I have attached** an original letter from an authorized representative of DDS which confirms my status as a DDS client.

☐ I am a veteran with a disability rating of 70% or greater. **I have attached** an original letter from the VA, signed by a Veteran's Services Officer, which specifies my disability rating.

If you checked one of the above boxes, then you do not need to complete PART C.

☐ **I need to submit PART C**. I do not fall into either of the above two categories, therefore I have provided the SSA with information from my licensed health care professional. I have attached documentation in completion with the requirements set in PART C.

I hereby certify under penalties of perjury that the information provided here and the attached proof of medical history is true and correct. I hereby authorize the Steamship Authority to contact and communicate with any and all persons who might have knowledge of this information for the purpose of verifying its truth and accuracy.

APPLICANTS SIGNATURE: DATE:

509 Falmouth Road, Suite 1C • Mashpee, Massachusetts 02649 • Telephone: (508) 477-8600
Email: acampbell@steamshipauthority.com • Fax: (508) 457-4518

PART C

HEALTH CARE CERTIFICATION TO BE COMPLETED BY A LICENSED/CERTIFIED HEALTH CARE PROFESSIONAL

Please answer all applicable questions thoroughly on this page. Review and complete the "GUIDELINES FOR HEALTH CARE PROFESSIONALS" on the next page. Eligibility for this applicant will be determined based on the information you supply.

Heath Care Professional's Info:

NAME: LICENSE # / STATE:

BUSINESS ADDRESS: CITY: STATE: ZIP CODE:

PHONE: LICENSURE TITLE:

EMAIL:

QUESTIONS:

1. What is the applicant's disability?

2. In what way does this cause the applicant difficulty when traveling on mass transit?

3. Is this disability:
   Short Term (under 6 months) ☐ Temporary (over 6 months) ☐ Permanent? ☐

4. Does applicant have a mobility or coordination disability? Yes ☐ No ☐
   if yes, explain:

   What type of mobility device (if any) does applicant use?

5. Does applicant's disability cause dyspnea upon exertion? Yes ☐ No ☐
   if yes, explain:

6. Does the applicant suffer from a serious long term mental illness that includes a substantial disorder of thought, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet demands of life and/or, as a result of serious long term mental illness, is the applicant unable to meet independent life support needs of food, shelter, clothing, management of finances, and health care?

   Yes ☐ No ☐ if yes, please describe nature and severity of impairment:

7. Is applicant able to hear signals/announcements, read signs and follow instructions in the event of an emergency?

   Yes ☐ No ☐ if no, explain:

GUIDELINES FOR HEALTH CARE PROFESSIONALS

APPLICANT INFORMATION

Please indicate below which of the categories apply to the applicant. Be sure to include any additional information we request in the space indicated at the bottom of the page or attached documentation. Check all that apply:

- ☐ **NON-AMBULATORY DISABILITIES**
  Those who require the use of a walker, crutches, or leg braces.
- ☐ **SEMI-AMBULATORY DISABILITIES**
  Those who require the assistance of a wheelchair.
- ☐ **MUSCULOSKELETAL CONDITIONS**
  Such as muscular dystrophy, ontogenesis imperfect or rheumatism restrictions. *Please specify therapeutic grade according to ARA, and indicate which limbs are affected.*
- ☐ **AMPUTATION OF AN EXTREMITY**
  Please specify which limb(s) are affected
- ☐ **SEVERE EFFECTS FROM CVA (STROKE)**
  Eligible conditions include functional motor deficit affecting any two limbs or ataxia 4 months' post CVA.
- ☐ **SEVERE PULMONARY CONDITIONS**
  That affect mobility. *If this section is applicable, please attach a copy of the most recent pulmonary function tests*
- ☐ **SEVERE CARDIAC CONDITIONS**
  If this section applicable, please include functional class of impairment and therapeutic grade as defined by the N.Y. HEART ASSOCIATION
- ☐ **PERSONS REQUIRING KIDNEY DIALYSIS TREATMENT**
- ☐ **VISION IMPAIRMENTS**
  Those who are visual in the better eye, after correction, is *20/200* or worse, or visual field is contracted ("tunnel vision").
- ☐ **HEARING IMPAIRMENTS**
  Deafness or hearing loss of 90 db or greater in the 500, 1,000, and 2,000 HZ ranges. *Please specify below the degree response in each of these ranges.*
- ☐ **COORDINATION DISABILITIES**
  Those persons with a functional motor deficit in any two limbs or experience manifestations which significantly reduce mobility. coordination and/or perception
- ☐ **MENTAL RETARDATION**
  Please include I.Q.
- ☐ **CEREBRAL PALSY**
  Please include extent of difficulty in motor function
- ☐ **EPILEPSY (CONVULSIVE DISORDER)**
  Please include severity and frequency of seizure activity despite medication
- ☐ **AUTISM**
  Please describe nature and severity of impairment.
- ☐ **NEUROLOGICAL DISABILITIES**
  Affecting perceptual and behavioral functioning. *Please include nature of condition and etiology*
- ☐ **PSYCHIATRIC DISABILITIES**
  This section applies to those individuals who suffer from a serious, long-term mental illness, and/or as a result of serious, long-term mental illness, the individuals are unable to meet independent life support needs of food, shelter, clothing management of finances, and health care. *Please indicate description and duration of condition*
- ☐ **PROGRESSIVE ILLNESSES**
  Including Acquired Immune Deficiency Syndrome and/or cancer. The disease must impact the performance of the applicant's organic system so the symptoms produced fall within one of the above categories.

Which above category is relevant to the applicant and any requested explanation:

_____

_____

Please provide us with any additional information that you feel would help us to make our decision regarding eligibility:

_____

_____

LICENSED HEALTH CARE PROFESSIONAL PLEASE SIGN BELOW

I hereby certify under penalties of perjury that the information provided here and the attached proof of medical history is true and correct.

_____

LHCP Signature: Date: