



Woods Hole, Martha's Vineyard and Nantucket Steamship Authority

Steamship Authority Accessibility Pass Program

Individuals with disabilities may apply for a Steamship Authority Accessibility Pass. When approved and issued by the Authority, the pass entitles the holder to a discounted fare upon its presentation with appropriate identification to a ticket seller.

In order to be eligible for an Accessibility Pass, an individual must fall into one of the categories listed below **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 licensed/certified health care professional*, **AND EITHER**
 - 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 health care professional, demonstrating the applicant falls under one of the above eligibilities, along with Part C, completed on the application.

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

POSTAL MAIL:

Steamship Authority
Attn: Angela Campbell
509 Falmouth Road, Suite 1C
Mashpee, MA 02649

EMAIL:

acampbell@steamshipauthority.com

FAX:

(508) 457-4518

** 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.*



Woods Hole, Martha's Vineyard and Nantucket Steamship Authority

ACCESSIBILITY 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 ADDRESS:

Emergency Contact:

NAME:

RELATIONSHIP:

MAILING ADDRESS:

CITY/STATE:

ZIP CODE:

EMAIL ADDRESS:

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 that 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.

APPLICANT'S SIGNATURE:

DATE:

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.

Health Care Professional's Information:

NAME:

LICENSE NO. & STATE:

BUSINESS ADDRESS:

CITY/STATE:

ZIP CODE:

PHONE:

LICENSURE TITLE:

EMAIL ADDRESS:

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:

- | | |
|--|--|
| <p><input type="checkbox"/> NON-AMBULATORY DISABILITIES
Those who require the use of a walker, crutches, or leg braces.</p> <p><input type="checkbox"/> SEMI-AMBULATORY DISABILITIES
Those who require the assistance of a wheelchair.</p> <p><input type="checkbox"/> MUSCULOSKELETAL CONDITIONS
Such as muscular dystrophy, ontogenesis imperfect or rheumatism restrictions. Please specify therapeutic grade according to ARA, and indicate which limbs are affected.</p> <p><input type="checkbox"/> AMPUTATION OF AN EXTREMITY
Please specify which limb(s) are affected</p> <p><input type="checkbox"/> SEVERE EFFECTS FROM CVA (STROKE)
Eligible conditions include functional motor deficit affecting any two limbs or ataxia 4 months' post CVA.</p> <p><input type="checkbox"/> SEVERE PULMONARY CONDITIONS
If these conditions affect mobility, please attach a copy of the most recent pulmonary function tests</p> <p><input type="checkbox"/> SEVERE CARDIAC CONDITIONS
If this section applicable, please include functional class of impairment and therapeutic grade as defined by the N.Y. HEART ASSOCIATION</p> <p><input type="checkbox"/> PERSONS REQUIRING KIDNEY DIALYSIS TREATMENT
Those who are visual in the better eye, after correction, is 20/200 or worse, or visual field is contracted ("tunnel vision").</p> <p><input type="checkbox"/> 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.</p> | <p><input type="checkbox"/> COORDINATION DISABILITIES
Those persons with a functional motor deficit in any two limbs or experience manifestations which significantly reduce mobility. coordination and/or perception</p> <p><input type="checkbox"/> MENTAL RETARDATION
Please include I.Q.</p> <p><input type="checkbox"/> CEREBRAL PALSY
Please include extent of difficulty in motor function</p> <p><input type="checkbox"/> EPILEPSY (CONVULSIVE DISORDER)
Please include severity and frequency of seizure activity despite medication</p> <p><input type="checkbox"/> AUTISM
Please describe nature and severity of impairment.</p> <p><input type="checkbox"/> NEUROLOGICAL DISABILITIES
Affecting perceptual and behavioral functioning. Please include nature of condition and etiology</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 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.</p> |
|--|--|

Which above category is relevant to the applicant? Please include any requested explanation.

Please provide us with any additional information you feel would be helpful to our review:

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.