PART B - MEDICAL PRACTITIONER/OCCUPATIONAL THERAPIST TO COMPLETE

The Taxi Subsidy Scheme is intended to improve the mobility and independence of people who are unable to use public transport because of severe or profound activity limitations. It is not intended to remedy the limitations of public transport coverage or frequency.

A 'severe disability' for the purposes of the ACT Taxi Subsidy Scheme means:

1. Severe mobility limitation;
2. Legal blindness, as defined for social security purposes;
3. Severe vision impairment;
4. Severe cognitive/intellectual/psychiatric impairment;
5. Severe and uncontrolled epilepsy.

A designated ACT Government officer will make the final assessment regarding the approval of this application based on the information provided in this form.

For our assessment of this application, your responses to the following questions are essential. All information will be treated confidentially. If you wish to discuss the applicant's situation, please phone (02) 6207 0028 (option 5).

Please note, if all the required information is not provided, an assessment cannot be completed.

Applicant Name:		**Date of birth:**	

Please provide details of the applicant's diagnosis or disability that are relevant to their ability to use public transportation:

Diagnosis or disability: *(Please do not use acronyms)*	**Date of onset:**

1. Does the applicant's disability prevent them using public transport?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Unsure

2. Is the applicant undergoing active treatment or rehabilitation? ☐ Yes ☐ No

3. Is the applicant's condition likely to:

☐ Deteriorate ☐ Stay the same ☐ Improve ☐ Unsure

RECOMMENDED PERIOD OF MEMBERSHIP

Please select the membership type/period you recommend for the applicant:

☐ **Temporary Membership**
For temporary or short-term conditions which prevent the use of public transport for a designated period. Please indicate when you expect the person to stabilise or regain enough function to be able to use public transport:

- ☐ 3 months or less
- ☐ 6 months
- ☐ 12 months
- ☐ 18 months
- ☐ 2 years
- ☐ 3 years

☐ **Permanent Membership**
For conditions which are permanent or unlikely to improve.

LOSS OF FUNCTION

Please tick the eligibility category or categories that apply in relation to this application:

☐ **Severe mobility limitation –** *please complete category 1*

☐ **Legal blindness or severe vision impairment –** *please complete category 2*

☐ **Severe cognitive/intellectual/psychiatric impairment** – *please complete category 3*

☐ **Severe and uncontrolled epilepsy –** *please complete category 4*

CATEGORY 1 - MOBILITY

1.1 Does the applicant experience a physical impairment (e.g., paralysis, loss of limb(s), arthritis, circulatory or respiratory diseases) which affects their capacity to use public transport?

☐ Yes ☐ No

1.2 Does the applicant use a walking aid?

☐ Yes ☐ No

1.3 If yes, what type of aid is used?

☐ Walking frame

☐ Wheeled walking frame

☐ Crutches

☐ Walking stick

☐ Wheelchair

☐ Scooter

☐ Other aid

1.4 Does the applicant permanently require use of a wheelchair?

☐ Yes ☐ No

1.5 Is the applicant able to use a standard taxi?
(Select 'No', if a wheelchair taxi is required)

☐ Yes ☐ No

1.6 How does the applicant's mobility limitation affect their ability to use public transport?

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CATEGORY 2 - VISION

2.1 Is the applicant visually impaired?

☐ Yes ☐ No

2.2 Does the applicant meet the eligibility criteria for legal blindness?

☐ Yes ☐ No

2.3 What is the applicant's best corrected visual acuity using the Snellen Scale?

Right eye: .....

Left eye: .....

2.4 Please give details of any visual field loss (in degrees): Right eye: .....

Left eye: .....

2.5 How does the applicant's vision impairment affect their ability to use public transport?

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CATEGORY 3 – COGNITIVE, INTELLECTUAL OR PSYCHIATRIC

3.1 Does the applicant have one of the following impairments?

☐ Cognitive

☐ Intellectual

☐ Psychiatric

3.2 Is the applicant undergoing or have they undergone, special travel training? ☐ Yes ☐ No

3.3 If yes, please comment on the expected outcome of this training.

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3.4 How does the applicant's cognitive, intellectual, or psychiatric impairment affect their ability to use public transport?

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CATEGORY 4 - EPILEPSY

4.1 Does the applicant have a diagnosis of severe and uncontrolled epilepsy? ☐ Yes ☐ No

4.2 If yes, please comment on episode history:

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4.3 How does the applicant's epilepsy affect their ability to use public transport?

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Other comments:

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APPROVED HEALTH PRACTITIONER'S DETAILS

Doctor's/Occupational Therapist's name:		
Qualification(s):		
Work address:	Street number & name:	
	Suburb:	
	State:	Postcode:
Phone number:	( )	
Email:		
Medical or other health professional board registration number or Medicare provider number:		

I CERTIFY THAT I HAVE COMPLETED THE RELEVANT DETAILS IN PART B AND THAT THIS INFORMATION IS CORRECT TO MY KNOWLEDGE.

Signature: .....

Date: .....

Medical Stamp: