Membership Application ACT Taxi Subsidy Scheme

The Taxi Subsidy Scheme (TSS) subsidises the transport costs of eligible individuals who are unable to use public transport due to a severe or profound activity limitation. This supports social inclusion and economic participation of community members who would otherwise be at risk of social isolation.

ELIGIBILITY

To be eligible for the ACT Taxi Subsidy Scheme, you must:

1. Be a permanent resident of the ACT or an asylum seeker with proof of status from Companion House.
2. Have a severe or profound activity limitation that prevents you from using public transport including:
   a. Severe mobility limitation (details of which must be provided);
   b. Legal blindness or severe vision impairment;
   c. Cognitive/intellectual/psychiatric disability; and/or
   d. Severe and uncontrolled epilepsy.
3. Not be a member of an interstate taxi subsidy scheme.

FACTORS THAT WILL NOT BE USED TO DETERMINE ELIGIBILITY:

- Income;
- Eligibility for other subsidy, concession or pension schemes within the ACT;
- Availability of, or proximity to, public transport; and
- Length of journey or timetable problems or inconvenience when using public transport.

APPLYING FOR MEMBERSHIP:

1. **Part A** - Complete and sign the declaration in the attached application form.
2. **Part B** - Take the form to an authorised medical professional/OT to complete.
3. **Enclose a photocopy of a document demonstrating permanent ACT residency** (*e.g.: current Centrelink card, utilities account, bank statement, ACT Services Access Card).*
4. **Enclose a full colour passport size photograph**.
5. In a situation where an applicant is unable to complete or sign an application, please provide either **Guardian or Power of Attorney certified documentation.**
6. The completed application form and supporting documentation can be emailed to concessions@act.gov.au or posted to:

   ACT Taxi Subsidy Scheme
   ACT Revenue Office
   GPO Box 293
   CANBERRA ACT 2601

Applicants will be notified on the outcome of assessment within 25 working days unless further information is required.

Applicants deemed ineligible for scheme membership may request an internal review of the decision within 30 days from the date of notification. Request for an internal review needs to be made in writing with further supporting documentation from a health care professional e.g., GP, specialist, physiotherapist.

PART A – APPLICANT DETAILS

Applicant to complete all of Part A, sign the declaration & provide proof of ACT residency.

Family name:		
First name:		
Middle name(s):		
Date of birth:		
Current residential address:	Street number & name:	
	Building/complex name (if applicable):	
	Suburb:	
	State:	Postcode:
Postal address: (If different from above)	Street number & name:	
	Building/complex name (if applicable):	
	Suburb:	
	State:	Postcode:
Daytime telephone:	( )	
Mobile number:		
Email address:		
Preferred method of contact:	☐ Email ☐ Post ☐ Alternative Contact	

ALTERNATIVE CONTACT PERSON:

Name of contact:	
Relationship to applicant:	
Contact phone number:	
Email address:	

	YES	NO
1. Are you a permanent resident of the ACT?	☐	☐
2. Have you previously applied for or joined the ACT Scheme?	☐	☐
3. Are you a member of an interstate taxi subsidy scheme?	☐	☐
4. Do you require assistance with communication/language?	☐	☐

Assistance required: .....

5. Are you able to use a standard taxi? (No, if wheelchair taxi required)	☐	☐
6. Does your disability affect your ability to use the bus?	☐	☐

Additional Comments / Information:

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DECLARATION:

The information you are asked to provide on this form will be kept confidential and only used to determine eligibility for membership of the Scheme and to inform the ACT Government of transport needs for people with disabilities.

☐ I certify that I am unable to use public transport due to my disability and that the information provided on this form is correct.

☐ I understand that if my application is approved, I may be required to undergo periodic reviews to confirm my continued eligibility to access the subsidy.

☐ If this application is approved, I will abide by the conditions governing the use of this scheme and acknowledge that any misuse of the subsidy provided may lead to the cancellation of membership and/or legal action.

☐ I consent to my doctor or occupational therapist providing the necessary information required by the ACT Taxi Subsidy Scheme for the purpose of assessing my eligibility for membership of the Scheme.

☐ I consent to my information being provided to Cabcharge and to be used to inform the ACT Government of transport needs for people with disabilities.

Name of applicant: .....

Applicant signature: ..... **Date:** .....
(If not signed by applicant, please provide a copy of Power of Attorney or Guardianship documentation)

Privacy Statement: *Information collected by the ACT Revenue Office (ACTRO) is protected by secrecy provisions contained in Acts administered by ACTRO and is used for the purposes of administering those Acts. In addition, personal information and personal health information provided to ACTRO is protected by the Information Privacy Act 2014 and the Health Records (Privacy and Access) Act 1997 , respectively. Information (including personal information) is not disclosed to any third party without the consent of the person involved, unless authorised by law.*

Please go to our website www.revenue.act.gov.au to read or print out a copy of our privacy policy which sets out how personal information is collected, used and disclosed by the Commissioner for ACT Revenue and the ACT Revenue Office, how you may access and seek correction of your personal information, and how you may complain about breaches of privacy.

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 <u>yes</u>, please comment on episode history:

.....

.....

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:

.....

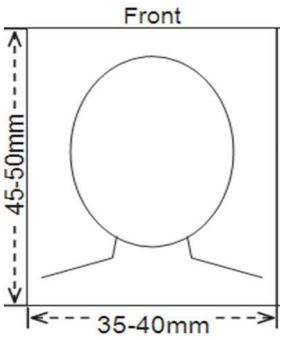
Date:

.....

Medical Stamp:

SMARTCARD PHOTO IDENTIFICATION

APPLICANT NAME:		DATE OF BIRTH:	



The photograph must:

- Be in colour
- Be no more than six months old
- Be passport size, which is 45-50mm high and 35-40mm wide
- If printing a hard copy photograph, it must be printed on photo-quality paper without visible pixels or dot patterns
- Have plain, light coloured background
- Show applicant's head and top of shoulders
- Show the applicant looking directly at the camera with eyes open (if possible)
- Show the applicant with his/her hat and sunglasses removed
- A high-resolution colour photo can be taken by a mobile phone and emailed with your application

If attaching the photo to this form, please use a paperclip only, DO NOT pin, staple or glue your photograph to this form.

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APPLICANT CHECKLIST

Please tick the following once completed:

PART A

☐ Personal details & questions

☐ Declaration signed (If not signed by the applicant, please provide Power of Attorney or Guardianship documentation).

PART B - MEDICAL PRACTITIONER/OCCUPATIONAL THERAPIST

☐ Completed by health professional as indicated for relevant criteria

☐ Doctor/Occupational Therapist signature and provider details

PROOF OF RESIDENCY

☐ A photocopy of a document demonstrating permanent ACT residency
(For example: current Centrelink card, utilities account, bank statement, ACT Services Access Card)

PHOTOGRAPH FOR SMARTCARD

☐ One full colour passport size photograph

Please send your completed application with proof of residency to concessions@act.gov.au or post to:

ACT Taxi Subsidy Scheme
ACT Revenue Office
GPO Box 293
CANBERRA ACT 2601