# Taxi Subsidy Scheme Application

Transport Operations (Passenger Transport) Regulation 2005

Queensland Government

## Please read the following instructions before completing this form.

### Eligibility

The Taxi Subsidy Scheme provides a subsidy for taxi travel at a half rate concession to people with **severe chronic disabilities**. Membership is given to those who fully meet **one** of the six eligibility categories listed below. The scheme is administered by the Department of Transport and Main Roads.
Applicants for the Taxi Subsidy Scheme must be permanent residents of Queensland. The scheme operates throughout Queensland and members of the scheme may use any taxi operator.

**The following reasons are <u>not</u> grounds for approval**

- Difficulty in accessing bus/train due to availability, timetable, remoteness or terrain;
- Financial constraints;
- Pension/concession card holder;
- Inability to drive;
- Episodic mobility problems; or
- Short term mobility restrictions of 5 months or less e.g. following acute injury, fracture or surgery.

### Eligibility Categories

Eligibility categories are determined by the *Transport Operations (Passenger Transport) Regulation 2005*. Under the existing eligibility categories, ***an applicant may be eligible to join this scheme if he or she falls under one of the following categories—***

| | |
|---|---|
| ***Category 1*** | Has a physical disability making the person dependant on a wheelchair for mobility outside the person's residence |
| ***Category 2*** | Has a physical disability or other medical condition that restricts the person from walking, unassisted and without a rest, 50 metres or less and—<br>(i) makes the person permanently dependant on a walking aid; or<br>(ii) prevents the person from ascending or descending 3 steps without assistance; or<br>(iii) has resulted in a history of frequent falls; or<br>(iv) is a condition that is an advanced cardiovascular, respiratory or neurological disorder; or<br>(v) causes severe pain limiting ambulation,verifiable by appropriate clinical investigations;<br>**or**<br>Has a physical disability or other medical condition requiring—<br>(i) the person to ordinarily carry treatment equipment which, when carried, restricts the person from walking, unassisted and without rest, 50 metres or less; or<br>(ii) someone else to ordinarily carry or administer treatment equipment for the person; |
| ***Category 3*** | Has a total loss of vision or severe permanent visual impairment; |
| ***Category 4*** | Has severe and uncontrollable epilepsy; |
| ***Category 5*** | Has an intellectual disability causing behavioural problems—<br>(i) resulting in socially unacceptable behaviour, and<br>(ii) requiring the constant assistance of someone else for travel on public transport; |
| ***Category 6*** | Has a severe emotional or behavioural disorder with a level of disorganisation resulting in the need to be always accompanied by another person for travel on public transport; |
| ***Categories 1 to 6*** | Has a clinical condition resulting in a disability mentioned in categories one to six of a temporary nature, and is undergoing medical, surgical or rehabilitative treatment for the disability, requiring the person to have access to taxi travel for a period of at least 5 months. |

## Processing of Applications

Applications are usually processed within six weeks of receipt.
The assessment process will take longer if further information is required.
The applicant will be notified if the application is delayed for any reason.
Incomplete applications may lead to refusal.

## Approved Applications

When an application is approved, the applicant will be advised in writing by the Department of Transport and Main Roads. A Taxi Subsidy member's smartcard will be posted to the applicant within two weeks of approval.
The Department of Transport and Main Roads will advise when reapplication is required.

## Unsuccessful Applications

If an application is unsuccessful, the applicant will be advised in writing by the Department of Transport and Main Roads. To have the outcome of an application reviewed, the applicant must apply in writing to the Department of Transport and Main Roads within 6 months with additional information provided by a doctor or allied health professional to support the severity of the disability. If further clinical information becomes available following an unsuccessful appeal this must be provided in a new application.
The Chief Executive of the Department of Transport and Main Roads or a delegate is ultimately responsible for all decisions regarding scheme membership.

## How to Apply

**Part A -** must be completed by the applicant or the applicant's carer or agent (refer page 3). Also the applicant's declaration must be completed, signed and dated by the applicant or the applicant's carer or agent (refer page 3).

The declaration by the witness of the photograph must be completed, signed and dated (refer page 3).

**Part B -** and the relevant category in **Part C** **must** be completed by the specified **Health Professional**.

## Post completed application, photos and any attachments to -

Taxi Subsidy Scheme
Department of Transport and Main Roads
PO Box 13347
Brisbane QLD 4003

## For information -

Phone - 1300 134 755
Fax - 3236 1579

**OR** for further information and/or to obtain a copy of this application form, please access the Department of Transport and Main Roads website: www.transport.qld.gov.au/tss

The information in this application form is for guidance only and is subject to the Transport Operations (Passenger Transport) legislation.

# Taxi Subsidy Scheme Application

## Part A - To be completed by the applicant or his/her agent

Queensland Government

### Applicant's details (please PRINT clearly)

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ ▶

Office Use Only
I.D No: _____ Member No: _____

Family name | Given name/s | Date of birth (/ /)

Current residential address

Postcode

Postal address *(if the same as the residential address, write 'as above')*

Postcode

Home number ( ) | Mobile number

Do you identify as Aboriginal or Torres Strait Islander? No ☐ Yes ☐

Are you currently an approved TSS member? No ☐ Yes ☐

Have you previously applied to join the scheme in Queensland? No ☐ Yes ☐

Do you currently drive a motor vehicle? No ☐ Yes ☐

What form of transport are you using at present?

Bus ☐ Family/ friends ☐ Own car ☐ Taxi ☐ Train ☐ Other ☐ ▶ Specify

Do you require a wheelchair accessible taxi? No ☐ Yes ☐

### Applicant's declaration

I declare that the information provided in this application is complete, true and correct in every detail.

***I authorise my doctor or other health professional to provide all information required for assessment of my application by an Assessment Officer.***

I understand that I may be interviewed if insufficient information has been provided for assessment.

I understand that if my application is approved there will be a subsequent review of my continued eligibility for membership and an interview may be required.

If this application is approved, I undertake to observe the conditions governing the granting of the subsidy and acknowledge that misuse of my travel card may lead to my withdrawl from the scheme and/or legal action or other penalties imposed by the Department of Transport and Main Roads.

I understand that costs associated with the completion of this form are my responsibility.

Applicant/carer's signature | Date (/ /)

Name of Applicant's Carer or Agent *(if required)* | Contact telephone no. ( ) | Relationship to applicant

### Declaration by witness of photograph

The witness must be satisfied that the photographs represent the applicant's true identity before completing the below section (please see example page 4).

I declare that I meet the requirements to make this declaration. I am satisfied that the photograph witnessed by myself represents the applicant's true identity.

Tick one box: Health Professional ☐ | Justice of the Peace or Commissioner of Declarations ☐ | Police Officer ☐ | Solicitor, Barrister or Judge ☐

Witness' full name | Signature of witness | Date (/ /)

### Office Use Only— Assessor to complete

Assessor's name | Signature | Date (/ /)

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐

Approved No ☐ Yes ☐ Duration _____ MEC _____

# Taxi Subsidy Scheme Application Part A continued....

## Declaration by witness of photograph

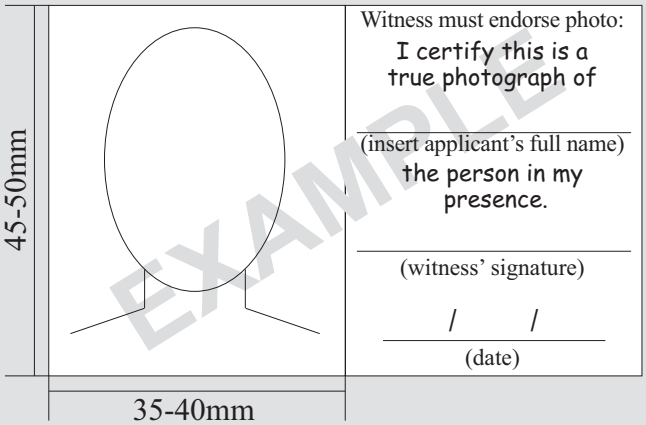
The witness must write the following statement and provide their signature and date on the back of one of the two photographs.

**The witness must be one of the following:**

- a health professional,
- a Justice of the Peace or Commissioner of Declarations,
- a police officer, or a solicitor, barrister or judge.

**The photographs must:**

- be no more than six months old, in colour and be passport size.




**Attach photo with a paperclip only, DO NOT pin, staple or glue your photographs to this form**

## Some helpful photograph tips

The Department of Transport and Main Roads understands that obtaining passport size photographs may be a challenge for some current and prospective TSS members. This is why the Department of Transport and Main Roads is accepting alternative and slightly lower standards for identification photographs than what is accepted for the issuing of passports and driver licences.

Both conventional and digital photography are acceptable, and conventional or digital printing methods may be used. However, digitally printed photos should be produced without visible pixels or dot patterns. Photos are not to be manipulated.

Passport photos can be obtained from selected chemists, camera and photo developing shops. Passport photo booths, typically found in large shopping centres, may also produce photos of sufficient quality.

With the accessibility and low cost of digital cameras and high quality home printers, passport photos may be produced in a home environment. Digital cameras with a resolution of at least 2 megapixels produce passport sized images of sufficient quality.

### Privacy disclaimer

The Department of Transport and Main Roads is collecting the information on this form to enable assessors from Queensland Health or their agents to assess the eligibility of the applicant for membership of the Queensland Taxi Subsidy Scheme. This information is required under the Transport Operations (Passenger Transport) legislation. The Department of Transport and Main Roads usually gives some or all of this information to Queensland Health for assessment.

Cabcharge Australia is contracted by the Department of Transport and Main Roads to produce TSS Member Smartcards. Your name, membership number, address and photograph will be disclosed to Cabcharge Australia for the purposes of producing your TSS Member Smartcard. After your TSS Member Smartcard has been dispatched to you, Cabcharge Australia will return your photograph to the Department of Transport and Main Roads. Cabcharge Australia will not store or release your name, address or photograph.

The Department of Transport and Main Roads will not disclose any individual's details to other third parties without their consent or unless required by law or for the purposes of Information Standard 42.

# Taxi Subsidy Scheme Application
# Part B

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**For ALL applications PART B is to be completed by a specified health professional as indicated in the heading of each category in PART C.**

## Guidelines for health professionals

- please ensure Part A has been completed by the applicant/carer
- advise applicant of requirement for two photographs *(one certified)*
- if requested, certify one photograph and complete witness declaration on page 3
- answer all questions below
- select the appropriate eligibility category from B8 below ***(select one only)***
- **ensure the specified health professional completes the application as authorised for each category**
- complete details for the selected category in Part C as indicated in B8 below
- sign and date the selected category
- attach relevant information **page 11**, for example reports and/or investigations *(if available)* to support the severity of the disability *(as authorised by the applicant in Part A)*
- stamp or print contact details clearly.
- all information provided about the applicant can be provided to the applicant under RTI.

**Please ensure that all relevant sections are completed. If not, the application will be returned - delaying the processing of the application. Your answers to the questions are critical to the assessment of the applicant's eligibility.**

**B1** Diagnosis or diagnoses relevant to this application | Date of Onset

**B2** Please provide a summary of clinical management *(e.g. medications, physiotherapy, surgery etc.)*

**B3** Is surgery being considered? Please provide status details

**B4** Please provide details of community services currently accessed

**B5** Do you consider the applicant has a severe disability?
No ☐ Yes ☐

**B6** Is the applicant's disability expected to:
Deteriorate ☐ Improve ☐ Remain stable ☐

**B7** For approximately how long has this applicant been in your care? *(e.g. 5 years or first consultation)*

**B8** Indicate **ONE** category for this application

| | | |
|---|---|---|
| **Category 1** ☐ | dependence on a wheelchair | **Complete page - 6** |
| **Category 2** ☐ | severe ambulatory problems | **Complete page - 6** |
| **Category 3** ☐ | severe visual impairment | **Complete page - 7** |
| **Category 4** ☐ | uncontrollable epilepsy | **Complete page - 7** |
| **Category 5** ☐ | severe intellectual impairment | **Complete page - 8** |
| **Category 6** ☐ | severe psychiatric or behavioural disorder | **Complete page - 9** |

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## Categories 1 and 2 - SEVERE MOBILITY IMPAIRMENT

Applications **may** be completed by a **Medical Practitioner, Registered Nurse, Physiotherapist** or **Occupational Therapist**

Symptoms limiting mobility

**Note:** Please attach copies of relevant existing reports which support the severity of the above symptoms. This clinical information is required for assessment *(reports such as, X-Ray, CT scan, Spirometry, Echo, ACAT)*.

Please list reports below and attach by stapling all information to Page 11 on the back of this form

Is the applicant able to stand from sitting independently?

No ☐ Yes ☐

Does the applicant use a mobility aid?

No ☐ Yes ☐ ▶ Where is the aid used?

Indoors ☐ Outdoors ☐

What is the frequency of use?

Always ☐ Occasionally ☐

Describe the type of mobility used *(e.g. scooter, wheelchair, crutches, walker, single point stick, quad stick)*

How far can the applicant walk before needing to rest due to the severity of symptoms? Please specify;

Independently without aid ____ metres

With mobility aid ____ metres

Does the applicant require assistance from another person for all mobility? Please specify;

No ☐ Yes ☐

### Health Professional details *(please PRINT)*

Name | Telephone number

Health profession

Address or stamp

Signature | Date / /

### General Practitioner details *(if different from above)*

Name | Telephone number

Address or stamp

Signature | Date / /

### Specialist details *(if different from above)*

Name | Telephone number

Address or stamp

Signature | Date / /

Approximate date of last consultation / /

Where did the last consultation take place?
*(e.g. hospital OPD, private practice clinic, private rooms)*



**Please ensure PART B on page 5 is completed**

# Part C
# Categories 3 and 4

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## Category 3 - VISUAL IMPAIRMENT

Applications **must** be completed by an **Ophthalmologist**

**Severe Visual Impairment**

Visual acuity (corrected)

6 / | 6 /

Have visual fields been tested?

No ☐ Yes ☐

Please detail

Date of last assessment

/ /

Does the applicant receive the Disability Support Pension (Blind)?

No ☐ Yes ☐

Does the severity of visual impairment approximate the requirement for a Disability Support Pension (Blind)?

No ☐ Yes ☐ Please provide details below

Has the applicant been reviewed in the last 12 months?

No ☐ Yes ☐ last review date / /

Where did the last consultation take place?
*(e.g. hospital OPD, private practice clinic, private rooms)*

### Ophthalmologist details *(please PRINT)*

Name | Telephone number

Address or stamp

Signature | Date / /

## Category 4 - EPILEPSY

Applications may be completed by a **General Practitioner** or **Medical Specialist**

**Epilepsy**

Applicants with epilepsy in a stable condition as a result of medication are not eligible for this scheme. Initial approval under this category is available for a period of 12 months. After this time further application will be required.

Type / description of seizure

Is there loss of consciousness?

No ☐ Yes ☐

How many seizures has the applicant had in the last 3 months? | Date of last seizure / /

Has the applicant been reviewed by a specialist in the last 12 months?

No ☐ Yes ☐ last review date / /

Specialist's name

Where did the last consultation take place?
*(e.g. hospital OPD, private practice clinic, private rooms)*

### General Practitioner details

Name | Telephone number

Address or stamp

Signature | Date / /

### Specialist details *(if different from above)*

Name | Telephone number

Address or stamp

Signature | Date / /

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## Category 5 - SEVERE INTELLECTUAL IMPAIRMENT *(including dementia)*

Applications **may** be completed by a **Medical Practitioner, Registered Nurse** or **Occupational Therapist**

Can the applicant travel independantly on public transport?

No ☐ Yes ☐

Please complete questions **A** to **G** below.

**A.** Degree of disability

Mild ☐ Moderate ☐ Severe ☐ Profound ☐

**Note:** Staple relevant information to page 11 *(e.g. MMSE Score, RUDAS, ACFI PAS, ACAT assessment)* and provide name and contact details of Paediatrician, Physician, Geriatrician etc.

**B.** Mobility

Independant? No ☐ Yes ☐

Please describe

**C.** Behaviour

Please describe

**D.** Safety of the applicant

Is the applicant at risk when using public transport?

No ☐ Yes ☐

Please clarify

**E.** Safety of others

Does the applicant's behaviour put the safety of others at risk?

No ☐ Yes ☐

Please clarify

**F.** Activities of daily living

Independent ☐ Requires supervision ☐ Requires assistance ☐

**G.** Education / Employment

Please comment on skills *(e.g. literacy, numeracy, money handling)*

Workplace / education facility attended *(if relevant)*

### Students Only

Has an Education Adjustment Profile *(EAP)* been completed?

No ☐ Yes ☐

Ascertainment level (*if available)*

Does Education Queensland provide school transport for this applicant?

No ☐ Yes ☐

### Health Professional details *(please PRINT)*

Name | Telephone number

Health profession

Address or stamp

Signature | Date

/ /

### Medical Practitioner details *(if different from above)*

Name | Telephone number

Specialty *(if applicable)*

Address or stamp

Signature | Date

/ /



**Please ensure PART B on page 5 is completed**

# Part C
# Category 6 *(A and B)*

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**SEVERE EMOTIONAL / BEHAVIOUR DISORDER**
with gross disorganisation restricting independent management of daily activities

## Category 6 A - SEVERE PSYCHIATRIC DISORDER

Applications **must** be completed by a **Psychiatrist**

Can the applicant travel independently on public transport?

No ☐ Yes ☐

Please comment on the severity of the disorder *(e.g. level of disorganisation, assistance required etc.)*

## Category 6 B - DEVELOPMENTAL DISABILITY or ORGANIC BRAIN SYNDROME

Applications **may** be completed by a **Medical Practitioner**

Can the applicant travel independently on public transport?

No ☐ Yes ☐

Please comment on the severity of the disorder *(e.g. level of disorganisation, assistance required etc.)*

To assist the assessment process please also complete questions **A** to **G** regarding functional ability under **Category 5** *(page 8)*

### Psychiatrist details *(please PRINT)*

Name

Telephone number

Address or stamp

Signature

Date / /

### Medical Practitioner details *(please PRINT)*

Name

Telephone number

Address or stamp

Signature

Date / /

**Note:** Initial approval under **Category 6 A** is available for a period of 12 months. After this time a further application will be required.



**Please ensure PART B on page 5 is completed**

## Assessor Use Only

Applicant's full name *(please PRINT)*

Age



### Request for information

Fax/ letter ☐ Telephone ☐ QT ☐

Initials

Date / /

### Outcome and reason for decision

Signature of Assessor

Date / /

# PLEASE ATTACH ADDITIONAL CLINICAL INFORMATION HERE