Taxi Subsidy Scheme Application

Queensland Government
Queensland Transport

Please read these 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 disabilities. Membership is given to those who fully meet ONE of the six eligibility categories listed below.
The Scheme is administered by Queensland Transport and applications are forwarded to Queensland Health for assessment.

Applicants for the Taxi Subsidy Scheme must be permanent residents of Queensland.

An applicant with a pension/concession card does not automatically qualify for membership of the scheme. Financial constraints, availability of or remoteness from public transport and inability to drive are not in themselves criteria for membership. This scheme is for persons with chronic disability and does not cover mobility restrictions following acute injury, fracture or surgery.

Membership of the Scheme

Application and assessment are required for membership of the scheme. Membership may be temporary or for 2 or 5 years as determined by the assessor.

Temporary membership applies to applicants who have a severe disability which meets the eligibility criteria for at least 6 months and could improve with medical or surgical treatment or rehabilitation.

Queensland Transport will advise when re-application and re-assessment are required for continued membership.

Where does the scheme operate?

The scheme operates throughout Queensland and members of the scheme may use any taxi operator.

Members may request vouchers for use interstate by phoning Queensland Transport on (07) 3253 4954.

Eligibility categories

1 Physical disability requiring dependence on a wheelchair for all mobility outside the home.

2 Severe ambulatory problem which cannot functionally be improved and restricts walking to an extremely limited distance.

3 Total loss of vision or severe visual impairment.

4 Severe and uncontrollable epilepsy with seizures involving loss of consciousness.

5 Intellectual disability resulting in the need to be accompanied by another person for travel on public transport at all times*.

6 Severe emotional and/or behaviour disorders with a level of disorganisation resulting in the need to be accompanied by another person at all times for travel on public transport.

* Note in **Cat 5.** Intellectual Disability includes Dementia.

Continued over page . . .

How to Apply

Part A of this form must be completed and **signed** by the applicant or the carer/agent of the applicant (refer page 3).

Prescribers must complete relevant sections of **Part B** (refer page 4).

This process may take up to 5 weeks if all relevant information is provided.

Processing of Applications

Each application will be assessed by a health professional (assessor) from Queensland Health. The assessor may request further information from the prescriber or the applicant and an interview may be required for assessment.

When an application is approved, an acceptance letter with a membership card and brochure will be posted to the applicant by Queensland Transport. A book of vouchers will be forwarded at a later date.

When an application is unsuccessful, the applicant will be advised in writing by Queensland Transport.

To appeal the outcome of an application, the applicant must appeal in writing to the Taxi Subsidy Scheme. Appeals are considered only if additional relevant clinical information supporting the severity of the disability is provided by a doctor or allied health professional.

Where to send completed forms

Completed application forms should be sent to:

Taxi Subsidy Scheme
Queensland Transport
PO Box 673
Fortitude Valley Qld 4006

Phone numbers:
(07) 3253 4954
(07) 3253 4635

Fax number:
(07) 3253 4696

For more information see the Queensland Transport website:
www.transport.qld.gov.au/qt/PubTrans.nsf/index/Subsidy

Privacy disclaimer - Queensland Transport 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. Queensland Transport usually gives some or all of this information to Queensland Health for assessment. Queensland Transport will not disclose any individual's details to other third parties without their consent or unless required by law.

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

Please Print Clearly

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other ☐ ______

Family name ***(please print)***

Given name/s

Date of birth

/ /

Residential address

Postcode

Postal address *(if same as residential write "as above")*

Postcode

Home phone number

( )

Business phone number *(if applicable)*

( )

Do you currently receive Taxi Subsidy Scheme Vouchers?

No ☐ Yes ☐

Have you previously applied to join the scheme in Queensland?

No ☐ Yes ☐ Approximate date / /

Do you currently drive a motor vehicle?

No ☐ Yes ☐

What form of transport are you using at present?

Family/friends ☐ Taxi ☐ Own Car ☐

Bus ☐ Train ☐ Other ☐ ______

Will you require a wheelchair accessible taxi?

No ☐ Yes ☐

continued next column . . .

Office Use Only - Membership No.

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 a Queensland Health 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 I may be required to be interviewed.

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

Costs associated with the completion of this form are my responsibility.

Applicant's signature Date / /

OR

Name of applicant's agent or carer *(please print)*

Contact phone number ( ) Relationship to applicant

Signature of applicant's agent or carer Date / /

Office use only

Instructions to Prescribers

Prescibers must complete **Part B** as follows:

(i) Answer Questions Q1 to Q5 below.
(ii) Complete details for the selected category as indicated (Q5)
(iii) Attach relevant information, reports and/or investigations (if available) to support the severity of the disability. Applicant's authorisation is on page 3.
(iv) Sign and date the selected category.
(v) Stamp or print prescriber contact details clearly.

The following are not grounds for approval:

1. Difficulty of access to bus/train due to availability, timetable, remoteness or terrain

2. Financial constraints

3. Pension/concession card eligibility

4. Inability to drive

5. The post-acute period following acute illness, injury or surgery

Failure to provide sufficient relevant information, as requested on the form, will result in a request for further information and will delay the assessment process.

Part B - To be completed by the specified Prescriber for each category.

Q1 Diagnosis/es relevant to this application.

Q2 Approximate date of onset of each condition

Q3 Please outline current or proposed management of symptoms relevant to this application - eg. medications, physiotherapy, surgery etc.

Q4 Is the severity of the applicant's disability expected to improve? Please comment.

Q5 Under which category do you consider the applicant is eligible? See list of categories on page 1. (Please tick *ONE BOX* only)

1. ☐ Go to Category 1 on page 5.	4. ☐ Go to Category 4 on page 6.
2. ☐ Go to Category 2 on page 5.	5. ☐ Go to Category 5 on page 7.
3. ☐ Go to Category 3 on page 6.	6. ☐ Go to Category 6 on page 8.

Form continued next page ...

1 2

To be completed by a Medical Practitioner, Registered Nurse, Physiotherapist or Occupational Therapist when applying for membership under Category 1 or 2. Page 4 must also be completed.

List any symptoms which limit mobility e.g. pain, shortness of breath, impaired balance, etc.

Please provide current clinical information to support the severity of the above symptoms which restrict walking, e.g. use of domiciliary oxygen and attach copies of relevant reports e.g. - Specialist, Xray, CT scan, Spirometry, ACAT.

Is the applicant able to stand from sitting independently?

Yes ☐ No ☐

Can the applicant ascend and descend 3 stairs independently (using rail)?

Yes ☐ No ☐

How far can the applicant walk before symptoms necessitate rest?

Independently without aid ______ metres   With mobility aid (if used) ______ metres   With assistance of another person ______ metres

Does the applicant use a mobility aid e.g. wheelchair, crutches, walker, stick? No ☐ Yes ☐

Describe aid used

Where is aid used?

Indoors ☐ Outdoors ☐

Frequency of use?

Always ☐ Occasionally ☐

Is this application for 2 or 5 year membership or temporary membership?

2 year membership ☐
5 year membership ☐

Temporary membership ☐ ▶ For how many months is temporary membership required? 6 ☐ 9 ☐ 12 ☐

Details of health professional completing this category

Name ***(please print)***

Health Profession

Address

Contact phone number ( )

Signature

Date / /

Provide contact details of general practitioner and/or provide contact details of specialists/s consulted.

Name of general practitioner ***(please print)***

Name of Specialist ***(please print)***

Contact phone number ( )

Contact phone number ( )

Specialty

Form continued next page ...

3 To be completed and signed by an Ophthalmologist when applying for membership under Category 3. Page 4 must also be completed.

Applicants must have severe visual impairment (both eyes), entitling them to Aged Blind Pension or the Disability Support Pension (Blind) or have a similar level of severe visual impairment.

Visual acuity (corrected)

Right 6/ Left 6/ Visual fields (when relevant)

Date of last assessment / /

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

No ☐ Yes ☐ ▶ A photocopy of the card may be attached

Does the severity of the visual impairment approximate the requirement for one of the above pensions?

No ☐ Yes ☐ ▶ Please provide relevant details

Is this application for 2 or 5 year membership or temporary membership?

2 year membership ☐
5 year membership ☐

Temporary membership ☐ ▶ For how many months is temporary membership required? 6 ☐ 9 ☐ 12 ☐

Treating ophthalmologist's details

Name ***(please print)***

Address

Contact phone number ( )

Signature of **ophthalmologist**

Date / /

4 To be completed by the treating Medical Practitioner when applying for membership under Category 4. Page 4 must also be completed.

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

Type/description of seizure

Number of seizures during the last 3 months

Date of last seizure (approximate) / /

For how many months is temporary membership required? 6 ☐ 9 ☐ 12 ☐

Treating medical practitioner's details

Name ***(please print)***

General Practitioner ☐ **or** Specialist ☐ ▶ Specialty

Address

Contact phone number

Signature

Date / /

Form continued next page ...

5 To be completed by a Medical Practitioner, Registered Nurse, Physiotherapist or Occupational Therapist when applying for membership under Category 5. Page 4 must also be completed.

Is the applicant permanently intellectually impaired to such an extent that he/she cannot travel on public transport without the assistance of another person at all times? No ☐ Yes ☐

Describe how the disability relates to the need for the applicant to be accompanied at all times for travel. If insufficient space available please **attach** additional information.

(a) Degree of disability Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Provide assessment result if available e.g. Ascertainment Level (Education Dept), MMSE or ACAT assessment level

(b) Mobility Independent Yes ☐ No ☐

Please describe

(c) Behaviour e.g. Impulsive, inappropriate, aggressive.

(d) Safety of applicant e.g. Vision, hearing, orientation, memory, communication.

(e) Risk to others

(f) Activities of daily living Independent ☐ Supervision ☐ Assistance ☐

(g) Education/Employment e.g. Facility attended, literacy, numeracy, money handling.

(h)Travel training satisfactorily completed Yes ☐ No ☐ Proposed? Yes ☐ No ☐

Is this application for 2 or 5 year membership or temporary membership?

2 year membership ☐

5 year membership ☐

Temporary membership ☐ ▶ For how many months is temporary membership required? 6 ☐ 9 ☐ 12 ☐

Details of health professional completing this category

Name ***(please print)***

Health Profession

Address

Contact phone number

( )

Signature

Date

/ /

Provide contact details of medical practitioner if different from above

Name of medical practitioner ***(please print)***

Contact phone number

( )

Form continued next page ...

6

To be completed when applying for membership under Category 6

6A and 6B below relate to applicants who have gross disorganisation restricting independent management of daily activities.

6A. Applications for people with severe **psychiatric disorders** must be completed by a **Psychiatrist. Page 4 must also be completed**.

6B. Applications for people with severe developmental disability or organic brain syndrome may be completed by the treating **Medical Practitioner. Pages 4 and 7 (a-h) must also be completed.**

Does the disorder require the applicant to be accompanied at all times on public transport? No ☐ Yes ☐

Additional comments. (other relevant information may be attached)

Membership under Category 6 is available for a maximum period of 12 months. After this time a further application will be required.

For how many months is this temporary membership required? 6 ☐ 9 ☐ 12 ☐

Details of prescriber - Psychiatrist (6A) or Medical Practitioner (6B)

Name ***(please print)***

Specialty

Address

Contact phone number ( )

Signature

Date / /

Office Use Only

Part C - To be completed by a Queensland Health Assessor

Name of applicant

Under which category is this application being approved or refused?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐

Are you approving this application?

Yes ☐ **2 year** ☐ **5 year** ☐ **Temporary membership** ☐ **Temporary extension** ☐ **Duration** months

No ☐ Give reasons below (this section must be completed)

Assessor's name ***(please print)***

Assessor's signature

Date / /

R.F.I. Comments Fax/Letter ☐ Phone ☐ Queensland Transport ☐