ACT Government

ACT Revenue Office
ABN: 45 096 207 205

WHAT IS THE 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:

To apply for membership with the ACT Taxi Subsidy Scheme you need to:

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 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 acttaxischeme@act.gov.au or alternatively, post to:

ACT Taxi Subsidy Scheme
ACT Revenue Office
PO Box 293
CIVIC SQUARE ACT 2608

Applicants will be notified on the outcome of assessment with 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.

APPLICANT CHECKLIST

Please tick the following once completed:

PART A

☐ Personal Details & Questions

☐ Declaration Signed

PART B - MEDICAL PRACTITIONER/OCCUPATIONAL THERAPIST

☐ Completed by health professional as indicated for relevant criteria

☐ Doctor/ Occupational Therapist Signature

PROOF OF RESIDENCY

☐ A Photocopy of a document demonstrating **Permanent ACT Residency**
Example: *Current Centrelink card, Utilities Account, Bank Statement, ACT Services Access Car)*

PHOTOGRAPH FOR SMARTCARD

☐ One passport size photograph

Please note that if these areas are incomplete, your application will be returned to you.
Please send your completed application with proof of residency to acttaxischeme@act.gov.au or alternatively, post to:

ACT Taxi Subsidy Scheme
ACT Revenue Office
PO Box 293
CIVIC SQUARE ACT 2608

PART A - MEMBERSHIP APPLICATION FORM

Applicant to complete all of Part A, sign the declaration & provide proof of residency.
(PRINT clearly)

TITLE:	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ .....
FAMILY NAME:	
FIRST NAME:	
MIDDLE NAME (S):	
DATE OF BIRTH:	
CURRENT RESIDENTIAL ADDRESS:	Street name & number:
	Suburb:
	State: Postcode:
POSTAL ADDRESS: (If different from above)	Street name & number:
	Suburb:
	State: Postcode:
DAYTIME TELEPHONE:	( )
MOBILE NUMBER:	
EMAIL ADDRESS:	

ALTERNATIVE CONTACT PERSON

NAME OF CONTACT:	
RELATIONSHIP TO APPLICANT:	
CONTACT PHONE NUMBER:	
EMAIL ADDRESS:	

Office Use Only

Date Received.....

Signature.....

	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 I **may** be required to undergo a medical examination to be carried out by a third party health services provider in order to determine eligibility for the Scheme.

☐ 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 authorise my application form to be forwarded to a third party health services provider for assessment.

☐ I consent to my doctor or occupation 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:	
SIGNATURE OF APPLICANT:	
DATE SIGNED:	

PART B - MEDICAL PRACTIONER/OCCUPATIONAL THERAPIST TO COMPLETE

Must be completed by a Medical Practitioner or Occupational Therapist.

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 your situation please phone (02) 6207 0028

NAME:		**DOB:**	

DIAGNOSIS OR DISABILITY

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**

Please Note: If all the required information is not provided the application will be returned to your patient/client for full completion.

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 ☐ Don't Know ☐

RECOMMENDED PERIOD OF MEMBERSHIP:

Temporary Membership ☐

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

3 mths or less ☐ 6mths ☐ 12mths ☐ 18mths ☐ 2years ☐ 3years ☐

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 ☐

Legal Blindness or Severe Vision Impairment ☐

Severe Cognitive/Intellectual/Psychiatric impairment ☐

Severe and uncontrolled Epilepsy ☐

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?

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

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3.3 Is the applicant undergoing or have they undergone, special travel training?

Yes ☐ No ☐

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

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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 PRACTITIONERS DETAILS

Doctor's/Occupational Therapist's Name (please print)

.....

.....

Qualification(s)

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.....

Work Address:

.....

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Suburb: .....

Post Code: .....

Phone No (02) .....

Email:.....

Medical or other Health Professional Board Registration No. or Medicare Provider No

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

Signature: ☐

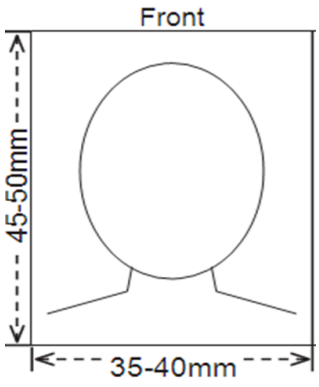
Date: ☐

Medical Stamp:

☐

SMARTCARD PHOTO IDENTIFICATION

NAME OF APPLICANT:	



The photograph must:

- Be no more than six months old
- Be passport size, which is 45-50mm high and 35-40mm wide
- Be in colour
- 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

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

Witness' Declaration Members Photograph

For the photograph to be accepted, we require your photograph to be witnessed and signed as a true copy.

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

I certify this is a true photograph of ***<Applicant's full name>*** the person in my presence

<Witness Signature>
<Date: DD/MM/YY>

Photos must be witnessed by one of the following:

1. Justice of the Peace
2. Medical Practitioner
3. Pharmacist
4. Nurse
5. Postal Manager
6. Any other person authorised to witness the signing of a statutory declaration

Please note it will take approximately 5-10 working days for the processing of your ACT Taxi Smartcard.