



## 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 limitations. 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 limitations** 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:

1. Income;
2. Eligibility for other subsidy, concession or pension schemes within the ACT;
3. Availability of, or proximity to, public transport; and
4. 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. Complete **Part A** and sign the declaration form of the attached application form;
2. Take the form to an authorised medical professional/ OT to complete **Part B**;
3. Enclose a photocopy of a document demonstrating **permanent ACT residency**. (e.g.: *Current Centrelink card, Utilities Account, Bank Statement, ACT Services Access Card, etc*)
4. Send the completed form and supporting documentation to:

ACT Taxi Subsidy Scheme  
GPO Box 158  
Canberra ACT 2601  
PHONE: (02) 6205 1012  
EMAIL: [acttaxischeme@act.gov.au](mailto:acttaxischeme@act.gov.au)

Applicants will be notified of the outcome of assessment within **25 working days**.

**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. For more information about the internal review process, please contact the Scheme.**



**PART A**

**Membership Application Form**

**Applicant:** Please complete all of **Part A**, sign the declaration & provide proof of residency.

**Examining Medical Professional or OT:** Please complete and sign **Part B**.

Applicant to complete (please PRINT clearly)

**Title:** Mr  Mrs  Miss  Ms  Other  Sex: M  F

**Surname:**

**Given Name:**

**Date of Birth:**  /  /

**Phone Numbers:**

**Email:**

**Residential Address:**

**Postal Address:**   
*(If different from above)*

**Alternative Contact Person**

**Name of Contact:**

**Relationship to applicant:**

**Phone Number:**

**Email:**

<b>Office Use Only</b>
Date
Received.....



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

Assistance required: .....

- 5. Are you able to use a standard taxi? Yes  No  (Wheelchair Taxi Required)
- 6. Does your disability affect your ability to use the bus? Yes  No

**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 to be used to inform the ACT Government of transport needs for people with disabilities.

**Name of Applicant:**

**Signature of Applicant:**  **Dated:**



## PART B Medical Practitioner/Occupational Therapist to Complete

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**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) 6205 1012.

**NAME:**

**D.O.B**

**DIAGNOSIS OR DISABILITY**

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

(Please do not use acronyms)

DATE OF ONSET

1.
2.
3.
4.
5.

- |                      |
|----------------------|
| <input type="text"/> |
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**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

4. If you expect the applicant's condition to **improve**, 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

**Recommended Period of Membership:**

Temporary Membership

*(For temporary or short term conditions which prevent the use of public transport for designated period of time) (As indicated in Q4)*

General 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 Go to **category 1** (Page 6)

Legal Blindness or Severe Vision Impairment Go to **category 2** (Page 6)

Severe Cognitive/Intellectual/Psychiatric impairment Go to **category 3** (Page 7)

Severe and uncontrolled Epilepsy Go to **category 4** (Page 7)



## 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/ 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)

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Qualification(s)

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Work Address:

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Suburb:

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Post Code:

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Phone No (02) .....

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Email:

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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:**

*Thank you for your assistance*