

## Application for Concessionary Travel Pass (Disabled or Blind)

### ① Your Details:

<b>Mr/Mrs/Miss/Ms:</b>			
<b>Surname:</b>		<b>Forename:</b>	
<b>Date of Birth:</b>		<b>Contact no:</b>	
<b>Address:</b>			
	<b>Postcode:</b>		
<b>Email Address:</b>			

### ② Automatic Eligibility:

You may **automatically** qualify for a disabled person's bus pass if you receive any of the following benefits:

	Yes	No
Higher rate mobility component of Disability Living Allowance	<input type="checkbox"/>	<input type="checkbox"/>
Personal Independence Payment (PIP) with an award of at least 8 points for "Moving Around" or "Communicating Verbally" activities	<input type="checkbox"/>	<input type="checkbox"/>
War Pensioners Mobility Supplement (WPMS)	<input type="checkbox"/>	<input type="checkbox"/>
Armed Forces Compensation Scheme	<input type="checkbox"/>	<input type="checkbox"/>
Blue Badge (Disabled Person's Parking Permit) issued by Calderdale Council	<input type="checkbox"/>	<input type="checkbox"/>

You need to be receiving these benefits for at least 12 months and you need to provide your award letter. If you are a Blue Badge Holder, please complete the below:

Blue Badge Number: \_\_\_\_\_ Expiry date: \_\_\_\_\_

### ③ Your Disability:

Please tick which of the following applies to you and provide the relevant supporting evidence.

Eligibility Criteria	Yes	No	Supporting Evidence required
<b>I am blind or partially sighted</b>			A certificate of Vision Impairment (CVI) <b>or</b> A BD8 form signed by a Consultant Ophthalmologist
<b>I am profoundly or severely deaf</b> <b>Supporting Evidence</b>			Evidence from your consultant <b>or</b> An audiological report from an aural specialist indicating hearing loss has reached 70-95 dBHL
<b>I am without speech or have severe communication difficulty</b> (please note that this does not include people who have slow speech or a severe stammer)			A letter from a health professional* confirming that you are unable to make clear, basic, oral requests; for example to ask for a particular destination or fare
<b>I do not have arms or have long-term loss of use of both arms</b>			A letter from a health professional* confirming that you are unable to use your arms to carry out day-to-day tasks such as paying coins to a bus driver
<b>I have a learning disability</b> (that is a state of arrested or incomplete development of mind, which includes significant impairment of intelligence and social functioning). This disability must have started before adulthood.			A letter from your Social Services key worker or a health professional* (including a member of your local Learning Disability Nursing Team) confirming that you have difficulty in learning new skills or may be unable to cope independently. These disabilities must have started before adulthood and have a lasting effect on development <b>or</b> Evidence of a statement of educational needs
<b>I have a disability or have suffered an injury which has a substantial and long term adverse effect on my ability to walk</b>			A statement from a health professional* confirming that you have a disability or have suffered an injury which has a substantial and long term impact on your ability to walk. This statement should include an assessment of the distance, time, speed and manor that you walk and whether this causes you discomfort, pain and/or breathlessness.
<b>You have been or would be refused a driving license</b> on certain medical grounds (You will not qualify if your condition is related to the persistent use of drugs or alcohol). <i>This includes conditions such as dementia, sudden attacks of dizziness or fainting, epilepsy (unless it is of a type which does not pose a danger if you drive) and any other disability which would cause you to be a danger to yourself or others when driving)</i>			A letter from the DVLA indicating refusal or withdrawal of your license for a minimum of 12 months <b>or</b> A letter from a health professional* confirming that you are unfit to drive, detailing the reason and the length of time you will be unfit to drive (this must be dated within the last 12 months)

**④ Medical Statement:**

**Not to be filled in if you have automatic Eligibility (section 2)**

\*Health care professionals who can provide supporting evidence include hospital consultants, occupational therapists, physiotherapists, general practitioners and nurses.

**Professional statement**  
Please indicate under which Eligibility Criteria you can support the customers' application for a disabled bus pass.

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<b>Professionals Name:</b>	<b>Official Stamp:</b>
<b>Position held:</b>	



**⑥ Declaration:**

I declare that the information given on this form is correct and if my application is approved, I agree to abide by the conditions of use issued by Metro.

**Signature** \_\_\_\_\_

*Or Parent, guardian or representative where necessary (if you are unable to sign).*

**Date** \_\_\_\_\_

**Please return completed forms along with proof of address in person to:**

**Halifax Customer First, 19 Horton Street, Halifax, HX1 1QE**

**Brighouse Customer First, Brighouse Civic Hall, Bradford Road, Brighouse, HD6 1RW**

**Elland Customer First, The Precinct, Southgate, Elland, HX5 0BW**

**Todmorden Customer First, Todmorden Community College, OL14 7BX**

OFFICE USE ONLY			
	Yes	No	Duration (years)
Pass awarded?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Companion awarded?	<input type="checkbox"/>	<input type="checkbox"/>	
Application ID:			Expiry: