



## Use this form to apply to the Taxi Subsidy Scheme (TSS).

The TSS subsidises taxi travel for people with a disability who meet the eligibility criteria.

### Eligibility criteria

You must be a permanent resident of Queensland and fully meet at least one of the following six eligibility criteria:

- Category 1. Physical disability requiring dependence on a wheelchair for all mobility outside the home.
- Category 2. Severe ambulatory problem that cannot functionally be improved and restricts walking to an extremely limited distance.
- Category 3. Total loss of vision or severe visual impairment (both eyes).
- Category 4. Severe and uncontrollable epilepsy.
- Category 5. Intellectual disability or dementia resulting in the need to be accompanied by another person at all times for travel on public transport.
- Category 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.

### Temporary approvals can be considered if you:

- have a clinical condition resulting in a disability mentioned in categories one to six of a temporary nature
- are undergoing medical, surgical or rehabilitative treatments for the disability, requiring you to have access to taxi travel for a period of at least five months.

### The following reasons are not grounds for approval:

- Difficulty in accessing bus/train due to availability, timetable, remoteness or terrain
- Financial constraints
- Pension/concession card holder
- Inability to drive
- Intermittent/occasional mobility issues experienced post treatment
- Short term mobility restrictions of five months or less, (for example, following surgery or acute injuries such as fractures).

### What you need to do

- Step 1. Complete applicant details - part A.
- Step 2. Provide one colour passport sized photo which has been witnessed.
- Step 3. A relevant certified health professional will need to complete part B and part C.
- Step 4. Submit your form, along with the certified health professional reports and photo.

### Send your completed application form and colour photo to:



**Email:** [tssu@translink.com.au](mailto:tssu@translink.com.au) (Submit photo in JPEG format and application and reports in PDF).



**Post:** Taxi Subsidy Scheme  
Department of Transport and Main Roads  
PO Box 13347  
BRISBANE QLD 4003

## Application processing

The Department of Transport and Main Roads (TMR) will register your application form before forwarding it to Queensland Health for an assessment of the clinical information provided.

### An incomplete application will be returned to you.

Applications are usually processed within four weeks of receipt.

If further clinical information is required from your certified health professional the assessment process may take longer.

## Health professional assessment

Use the table below to determine which one of the certified health professionals you need to see.

Certified health professional	Category 1	Category 2	Category 3*	Category 4	Category 5	Category 6
General practitioner	X	X		X	X	X
Registered nurse	X	X			X	
Physiotherapist	X	X			X	
Occupational therapist	X	X			X	
Ophthalmologist			X			
Optometrist			X			
Psychiatrist						X
Medical specialist	X	X		X	X	X

### For Category 3\* applications

If you are applying under Category 3, and hold one of the blind concession cards listed below, please only complete part A on the application form and attach a copy of your blind concession card to your application. This will verify your application.

- Australia Services concession card (blind)
- Department of Veterans' affairs concession card (blind)
- Aged Pension (blind)
- Visually Impaired Transit Pass (Translink)

You are only required to seek input from a certified health professional if you do not provide your blind concession card details.

## Approved applications

When an application is approved, you will be advised in writing by TMR.

A taxi subsidy smartcard that includes your photo will be posted to you within 14 working days of approval.

TMR will then advise you 12 weeks before your membership is due to expire for re-application.

All members of the scheme must inform TMR of any changes to their contact details.

\*\*Please read and remove this tear off page (not to be returned with this application)\*\*

## Proof of identity - photos

One colour passport sized photo must be witnessed on the back with the photo witness statement. As the witness will be your health professional, **you must ensure you have your photo with you before you see your certified health professional.** (Not applicable for Category 3)

If you email your application, you must attach in JPEG format an image of the front of your photo and the back with the completed witness statement.

If you post your application, you must attach your witnessed photo to the application form with a paper clip.

### The photo must:

- have your certified health professional's witness statement on the back of the photo
- be no more than six months old
- be in colour, printed on photo quality paper using a high resolution
- be passport size (45-50mm high x 35-40mm wide)
- be with a plain light coloured background
- show your head and top of shoulders
- show you looking directly at the camera and not tilted in any direction
- show you with a neutral expression
- show you without glasses or a hat.

### Witness requirements

The witness must be your certified health professional.

For Category 3 applicants, where you are submitting a copy of your blind concession card, your photo witness can:

- be an adult Australian citizen (over the age of 18) who has known you for more than one year
- not be any kind of relative, or in a defector relationship with you
- not be living at the same residential address as you.

### Witness instructions

For certified health professionals, write your name, date and signature on the back of the photo supplied by the applicant.

For Category 3 applications where the applicant is submitting their blind concession card, the following statement must be written on the back of the photo, "I certify this is a true photograph of (applicant's full name) the person in my presence" followed by your signature and the date.

The witness must complete the declaration by witness of photo section on page 5.

### If you need help:



**Email:** [tssu@translink.com.au](mailto:tssu@translink.com.au)



**Phone:** 1300 134 755



**Visit:** [www.tmr.qld.gov.au/tss](http://www.tmr.qld.gov.au/tss)

or scan the QR code.



**Applicant's details (please print clearly)**

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# Taxi Subsidy Scheme application part A (continued)

## Declaration by witness of photo

The witness must be satisfied that the photo represents the applicant's true identify before completing the below section. Your name and signature will only be used by TMR for the purposes of this application and will not be used or disclosed to a third party without your consent unless required by law.

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



If sending by post, attach photo here with paper clip.

Given name/s of witness  Family name of witness   
Signature of witness  Date  /  /

## Preferred contact method

Would you prefer to get updates about your TSS application or membership by email or post?

Email ☐ Post ☐

If you choose email:

- we will send you most of the updates by email. You may still receive some letters by post (e.g. if your application is approved, we will send you a physical TSS membership card)
- you agree to check your email regularly and let us know if you change contact details
- you can call us to switch to receiving all updates by post instead of email.

**Privacy statement:** TMR collects your information to assess your eligibility for TSS membership. This information is authorised by s120 of the TOPTR. Without this information, we are unable to assess your eligibility for TSS membership. TMR usually gives some or all your information to Queensland Health and the NDIS as authorised under s123 of the TOPTR. Your personal information will not be given to any other third party without your consent unless required or authorised by law. For further information about how we use your personal information and your right of access to it, please visit [www.tmr.qld.gov.au/help/privacy](http://www.tmr.qld.gov.au/help/privacy).

## Applicant's declaration

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

Relevant to my TSS application and verification of information, I consent to:

- assessors from Queensland Health and TMR to contact my relevant certified health professional for further information
- my certified health professional disclosing information about my disability or medical conditions to Queensland Health and TMR
- the release of personal information to other relevant government agencies such as Queensland Health and the National Disability Insurance Agency.

I understand:

- there are penalties for providing false or misleading information
- my certified health professional is required to provide information in this application to enable assessment of my application
- I must observe the conditions governing the granting of the subsidy and acknowledge that misuse of my TSS smartcard will lead to withdrawal from the scheme and/or legal action or other penalties imposed under the TOPTR
- costs associated with completing this form are my responsibility.

Applicant's signature  Date  /  /

Trusted person's signature  Date  /  /



## Guidelines for certified health professionals

Please read information on the TSS application (pages 1 to 3) before completing below.

- Please ensure part A has been completed by the applicant or trusted person.
- Advise applicant of requirement for photo.
- Certify photo and complete the photo witness declaration (see page 5).
- Complete details for the selected category in part C.
- If the applicant's disability **does not meet** the eligibility criteria for the categories as described in page 1, kindly advise the applicant that they do not meet the eligibility requirements for the TSS, as described in the current TOPTR. In these cases, please do not progress this application.

Please describe the diagnosis relevant to the category applied.


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

Is the applicant's disability permanent? Yes ☐ No ☐ Unsure ☐

Do you expect the applicant's disability to: Deteriorate ☐ Improve ☐ Remain stable ☐

## Declaration

I declare:

- the information provided in this application is complete, true and correct in every detail.

I understand that:

- TMR is collecting the information to enable assessors from Queensland Health and TMR to assess the eligibility of the applicant for membership of the TSS
- Queensland Health may contact myself for further clinical information
- all personal information will be used by TMR for the purposes of this application and will not be used without my consent unless required by law
- there may be consequences for providing false or misleading information.

## Certified health professional's details

General practitioner ☐ Registered nurse ☐ Physiotherapist ☐ Occupational therapist ☐

Ophthalmologist ☐ Optometrist ☐ Psychiatrist ☐ Medical specialist ☐

Name

Email address

Telephone number

AHPRA number

Signature

Date

Address


Postcode

Indicate one category for this application	Please tick	If temporary, please tick	Go to page
Category 1 - dependence of a wheelchair outside the home	<input type="checkbox"/>	<input type="checkbox"/>	7
Category 2 - severe ambulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	8
Category 3 - severe visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	9
Category 4 - uncontrollable epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	10
Category 5 - intellectual disability causing behavioural problems	<input type="checkbox"/>	<input type="checkbox"/>	11
Category 6 - severe emotional or behavioural disorder	<input type="checkbox"/>	<input type="checkbox"/>	12

# Application part C (Category 1) - dependency on wheelchair outside the home

To be completed by a General practitioner, Registered nurse, Physiotherapist, Occupational therapist or Medical specialist

Please describe symptoms limiting mobility


Does the applicant always require a wheelchair for mobility outside their residence?

Always ☐ Never ☐ Please do not proceed with this category of application. Please consider Category 2 overleaf.

Does the applicant's disability require them to remain seated in a wheelchair when travelling in a taxi?

Always ☐ Never ☐

Please provide clinical reports and/or assessments to support severity of symptoms.

Report or assessment	Please tick <input checked="" type="checkbox"/>
Cardiovascular or respiratory evaluations	<input type="checkbox"/>
Genetic report	<input type="checkbox"/>
Geriatrics report	<input type="checkbox"/>
Functional assessments	<input type="checkbox"/>
Musculoskeletal evaluation	<input type="checkbox"/>
Neurological assessment	<input type="checkbox"/>
Occupational therapist report	<input type="checkbox"/>
Physiotherapist report	<input type="checkbox"/>
Rheumatological evaluations	<input type="checkbox"/>
Rehabilitation reports	<input type="checkbox"/>
Specialist report	<input type="checkbox"/>
Other support plans	<input type="checkbox"/>

Other ☐

Is the applicant's disability permanent and unlikely to improve?

Yes ☐ No ☐ Unsure ☐



## Application part C (Category 2) - severe ambulatory problems

To be completed by a General practitioner, Registered nurse, Physiotherapist, Occupational therapist or Medical specialist

Please describe symptoms limiting mobility


Can the applicant walk, unassisted and without rest, for more than 50m?

Yes ☐ No ☐

**If yes, the applicant is not eligible under this category. Please do not proceed with this application.**

Please provide clinical reports or assessments.

Report or assessment provided	Please tick <input checked="" type="checkbox"/>
Six-minute walk test	<input type="checkbox"/>
Berg balance score	<input type="checkbox"/>
Mobility assessment	<input type="checkbox"/>
Timed up and go report	<input type="checkbox"/>

Other ☐

Does the applicant's disability require them to remain seated in a wheelchair when travelling in a taxi?

Always ☐ Never ☐

Can the applicant ordinarily carry treatment equipment and walk unassisted and without rest, for more than 50m?

Yes ☐ No ☐ N/A ☐

Is someone else required to ordinarily carry or administer treatment equipment for the applicant?

Yes ☐ No ☐ N/A ☐

Can the applicant ascend and descend three steps without assistance (using a handrail)?

Yes ☐ No ☐

Does the applicant permanently depend on a walking aid?

Yes ☐ No ☐

Does the applicant have a history of frequent falls?

Yes ☐ No ☐

Does the applicant have a physical condition or other medical condition that is an advanced cardiovascular, respiratory or neurological disorder?

Yes ☐ No ☐

Does the applicant's physical or medical condition cause severe pain limiting ambulation, verifiable by appropriate clinical investigations?

Yes ☐ No ☐

If you have answered 'Yes' to any of the questions, please provide clinical reports or assessments to support your assessment.

Report or assessment provided	Please tick <input checked="" type="checkbox"/>
Cardiovascular/respiratory evaluations	<input type="checkbox"/>
Cognitive assessment (MOCA; MMSE; ACE; RUDAS; ACFI/PAS)	<input type="checkbox"/>
Discharge summary	<input type="checkbox"/>
Functional assessments	<input type="checkbox"/>
Genetic report	<input type="checkbox"/>
Geriatrics report	<input type="checkbox"/>
Imaging (CT Scan, MRI, X-rays)	<input type="checkbox"/>
Musculoskeletal evaluation	<input type="checkbox"/>
Neurological assessment	<input type="checkbox"/>
Occupational therapist report	<input type="checkbox"/>
Other specialist reports	<input type="checkbox"/>
Pain medicine report	<input type="checkbox"/>
Physiotherapist report	<input type="checkbox"/>
Rheumatological evaluations	<input type="checkbox"/>
Rehabilitation reports	<input type="checkbox"/>
Support plans (NDIS, MACA)	<input type="checkbox"/>

Other ☐

Is the applicant's disability permanent and unlikely to improve?

Yes ☐ No ☐ Unsure ☐



## Application part C (Category 3) - visual impairment

To be completed by an Ophthalmologist or Optometrist

**Only to be completed if applicant does not choose to provide their concession card details.**

Is the applicant's visual acuity on the Snellen Scale after correction by suitable lenses of less than 6/60 in one eye, and 6/36 or less in the other eye?

Yes ☐ No ☐

Is the applicant's field of vision constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity?


Yes ☐ No ☐

Does the applicant have severe visual impairment combined with significant ambulatory problems, e.g., homonymous hemianopia with hemiplegia or ataxia?

Yes ☐ No ☐

If you have answered 'Yes' to any of the questions, please provide clinical reports or assessments to support your assessment.

Report or assessment provided	Please tick <input checked="" type="checkbox"/>
Discharge summary	<input type="checkbox"/>
Ophthalmologist/Optometrist's report	<input type="checkbox"/>
Visual field (perimetry) report	<input type="checkbox"/>

Other ☐ 

## Application part C (Category 4) - uncontrollable epilepsy

To be completed by a General practitioner or Medical specialist

Please describe type/description of seizure


Does the applicant have a diagnosis of epilepsy confirmed by a neurologist/physician?

Yes ☐ No ☐

**If 'No', please do not proceed with this application under this category. Please note applicants with epilepsy who are in a stable condition as a result of optimal anti-epileptic drug therapy are not eligible.**

Has the applicant experienced altered or impaired consciousness?

Yes ☐ No ☐

If you answered yes, please provide clinical reports demonstrating frequent, uncontrollable, and severe epilepsy.

Report or assessment provided	Please tick <input checked="" type="checkbox"/>
Discharge summary	<input type="checkbox"/>
Electroencephalogram test	<input type="checkbox"/>
Neurology report	<input type="checkbox"/>

Other ☐

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## Application part C (Category 5) - intellectual disability causing behavioural problems

To be completed by a General practitioner, Registered nurse, Physiotherapist, Occupational therapist or Medical specialist

Describe the degree of disability:

Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Does the applicant's disability result in socially unacceptable and or unpredictable behaviour on public transport, which would distract or have a negative impact on the safety of the driver or other passengers and constitutes a potential safety risk e.g. inappropriate verbalisation or behaviour such as lashing out, kicking?

Yes ☐ No ☐

Could the applicant's disability when using public transport result in self-injurious behaviour?

Yes ☐ No ☐

Could the applicant's disability when using public transport result in risk taking behaviours without an understanding of danger?

Yes ☐ No ☐

Does the applicant's disability require the constant assistance of someone else for travel on public transport?

Yes ☐ No ☐

Please provide clinical reports or assessments to support your assessment.

Report or assessment provided	Please tick <input checked="" type="checkbox"/>
Discharge summary	<input type="checkbox"/>
Paediatrics report	<input type="checkbox"/>
Support plans (NDIS; IAP; EAP)	<input type="checkbox"/>
Wechsler Adult Intelligence Scale	<input type="checkbox"/>

Other ☐

# Application part C (Category 6) - severe emotional or behavioural disorder

To be completed by a General practitioner, Psychiatrist or Medical specialist

Please indicate the nature of emotional and behavioural disorder	Please tick <input checked="" type="checkbox"/>
Acquired brain injuries	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>
Dementia	<input type="checkbox"/>
Dysthymic disorder	<input type="checkbox"/>
Major depressive disorder	<input type="checkbox"/>
Panic disorder with agoraphobia	<input type="checkbox"/>
Post-traumatic stress disorder	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>
Schizoaffective disorder	<input type="checkbox"/>

Other ☐

Describe the degree of disability:

Mild ☐ Moderate ☐ Severe ☐ Profound ☐

Does the applicant display significant limitations in social and interaction skills?

Yes ☐ No ☐

Does the applicant display ongoing behaviour disorders, including aggression, disinhibition?

Yes ☐ No ☐

Does the applicant display severe disorientation?

Yes ☐ No ☐

Is it unlikely that applicant's condition will improve?

Yes ☐ No ☐

Could the applicant's disability when using public transport result in risk taking behaviours without an understanding of danger?

Yes ☐ No ☐

Does the applicant's level of disorganisation result in the need to be always accompanied by another person for travel on public transport?

Yes ☐ No ☐

Please provide clinical reports or assessments to support your assessment.

Report and assessments provided	Please tick <input checked="" type="checkbox"/>
Cognitive assessment (MOCA; MMSE; ACE; RUDAS; ACFI/PAS)	<input type="checkbox"/>
Geriatrician report	<input type="checkbox"/>
K10 report	<input type="checkbox"/>
Life skills report	<input type="checkbox"/>
Neurologist report	<input type="checkbox"/>
Psychiatrist report	<input type="checkbox"/>

Other ☐