MINNESOTA DEPARTMENT OF PUBLIC SAFETY
DRIVER AND VEHICLE SERVICES

Print Form

Eligibility Verification for Reduced Fee ID Card

Bring or mail this completed form to any Minnesota driver exam station. For addresses, visit dvs.dps.mn.gov and click Locations in the top orange navigation bar. You may also mail the form to Driver and Vehicle Services, 445 Minnesota Street, St. Paul, Minnesota 55101-5175, or fax to (651) 282-2110. For questions, call (651) 297-3298 or (651) 282-6555 (TTY).

- A medical professional or case manager completes ***one*** of the following verifications, according to the following statute.

Minnesota Statutes, section 171.07, subdivision 3, paragraph (i): "The fee for a Minnesota identification card is 50 cents for a person who is either: developmentally disabled as defined in Minnesota Statutes, section 252A.02; physically disabled as defined in Minnesota Statutes, section 169.345, subdivision 2; or has serious and persistent mental illness as described in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c)."

I, as a licensed medical professional or case manager, verify that the following individual qualifies for a reduced fee Minnesota Identification Card according to the statute above. (PRINT OR TYPE)

First Name _____ Middle Name _____ Last Name _____ Date of Birth (mm/dd/yy) _____

VERIFICATION OF DEVELOPMENTAL DISABILITY ***(Needed only for initial application)***

X _____
Signature of MD or case manager

Date of Signature _____

Name and Title (PRINT OR TYPE) _____

Office Address _____

Phone number (TYPE - NO DASHES OR SPACES) _____

OR

VERIFICATION OF SERIOUS AND PERSISTENT MENTAL ILLNESS ***(Needed for initial application and renewal)***

X _____
Signature of MD or case manager

Date of Signature _____

Name and Title (PRINT OR TYPE) _____

Office Address _____

Phone number (TYPE - NO DASHES OR SPACES) _____

OR

VERIFICATION OF PHYSICAL DISABILITY

☐ Permanent physical disability
(verification needed only for initial application)

☐ Temporary physical disability for up to 4 years
(verification needed for initial application and renewal)

X _____
Signature of MD or case manager

Date of Signature _____

Name and Title (PRINT OR TYPE) _____

Office Address _____

Phone number (TYPE - NO DASHES OR SPACES) _____