Application for Reduced Fare Rider Identification Card- Persons with Disabilities

This application, when approved, entitles the applicant to a Reduced Fare Rider Identification Card. This card allows the applicant to ride any Wave Transit fixed route bus at the reduced rate. It is important to note this application is only applicable to persons with disabilities applying for a reduced fare card.

The cost of the identification card is $1.00. Card shall remain valid for a period of five (5) years. The Reduced Fare Rider Identification Card is not-transferable. Misuse of the card can result in the cardholder’s privilege to ride at a reduced fare to be rescinded.

The information requested in this application is confidential. Any release of information is for transit planning purposes only and in such cases the person’s name will not be used.

The Reduced Fare Rider Identification Card is administered by Wave Transit and is in compliance with all federal, state and local laws.

The undersigned hereby makes application for a Reduced Fare Rider Identification Card and agrees to abide by the provisions of the reduced fare program. By submitting this application, the undersigned agrees to release the information on this application to Wave Transit for the purpose of reduced fare eligibility verification.

_________________________ Signature of Applicant __________________ Date

________________________ APPLICANT PERSONAL INFORMATION (please print or type)

Last Name                   Middle Name                  First Name

Street Address               City                       State                       Zip Code

Phone                        E-mail Address

UPDATED 01.18.2017
CERTIFICATION BY PHYSICIAN OR OTHER LICENSED MEDICAL PROFESSIONAL

Please check the disability(s) which pertain to the individual listed above.

Physical Disabilities

A. ___ Individuals who walk with difficulty, including individuals using a leg brace, a walker, or crutches.
B. ___ Individuals with arthritis which causes a functional motor deficit in any major limb.
C. ___ Individuals who have had an amputation, anatomical deformity, or loss of major function of limbs, hands, feet (unless well compensated by prosthesis) or spine, neck or pelvic area.
D. ___ Cerebrovascular accident (stroke) causing the individual to have difficulty walking or standing.
E. ___ Pulmonary ills or individuals with respiratory impairment.
F. ___ Sight disabilities. Eligibility is limited to the legally blind.
G. ___ Hearing disabilities. Deafness or hearing incapacity, including only those whose discrimination for conversational speech is less than 40% (even with a hearing aid), as measured by standard audiometric tests.
H. ___ Cerebral Palsy. A disorder characterized by aberrations or motor function (paralysis, weakness, incoordination) often other manifestations, or traumatic brain injury.
I. ___ Epilepsy. Major motor seizures (grand mal or psycho motor) substantiated by EEG, occurring more than once a month in spite of prescribed treatment.
J. ___ Neurological disabilities. Eligibility is limited to neurological neuromuscular disorders which manifest sufficient restrictions in mobility, coordination, and / or perceptiveness. Such disorders may include: Parkinson’s disease, poliomyelitis, multiple sclerosis, amyotrophic lateral sclerosis, cerebella disorder, nerve injuries, neuropathies, muscular dystrophy, and impairment of vestibular function, (Meniere’s Syndrome).
K. ___ Other physical disability. Please list the medical diagnosis and provide a description of the disability (please print or type).

_____________________________________________________________________
_____________________________________________________________________

_____________________________
Non-Physical Disabilities

A. ___ Intellectual Disability. Included in this group are those individuals who exhibit deficits in intellectual functions (reasoning, problem-solving, judgement), and who also have deficits in adaptive functioning that limit communication, social participation, or independent living across multiple settings.

B. ___ Autism Spectrum Disorder. Individuals with this diagnosis often exhibit deficits in social communication and interactions, repetitive patterns of behavior, restricted interests/activities, and impairment in social, occupational, or other important areas of functioning.

C. ___ Other non-physical disability. Please list the medical diagnosis and provide a description of the disability (please print or type).

________________________________________________________________________

________________________________________________________________________

I certify that the applicant has a:

A ___ Permanent disability (at least five years)

B ___ Temporary disability until ____________, 20 ___

___________________________ Name of physician/licensed medical professional

Please provide your professional title/specialty and license number.

___________________________

___________________________ Signature of physician/licensed medical professional

___________________________ Date___________________________ Phone

Wave Transit Use Only

___________________________

Approved/Denied/Pending Date

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UPDATED 01.18.2017