

FRONT

Application for Regional Reduced Fare Permit For Senior Citizens and Disabled Persons

(this application is available in accessible format)

Please Print

Processing Fee \$3.00

- For Office Use Only -	
ID #	_____
PCA	_____
<input type="checkbox"/> Temporary	
<input type="checkbox"/> Permanent	
Date	_____

Name _____
First Middle Last

Address _____
Street City State ZIP

Date of Birth _____ Phone No. _____
Area Code

Please read the applicant section of the *Medical Eligibility Criteria and Conditions* brochure before completing this application.

I am applying for a Regional Reduced Fare Permit on the following basis. **Please check only one.**

- I am 65 years of age or older.
- I am providing proof of eligibility and am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability. For issuance of a Temporary Regional Reduced Fare Permit only.
- I am providing proof of current eligibility by the Veteran's Administration as having a disability of at least 40%.
- I am presenting a valid Medicare card issued by the Social Security Administration. For issuance of a Temporary Regional Reduced Fare Permit only.
- I am providing a valid Regional ADA paratransit card, issued by _____
(Agency)
This ADA paratransit card expires _____.
- I am providing a valid ADA paratransit card from outside the region. (For issuance of a Temporary Regional Reduced Fare Permit only.)
- I have an obvious physical impairment(s) meeting one or more of the medical criteria listed in the *Medical Eligibility Criteria and Conditions* brochure.
- I am currently participating in a vocational career program with the Washington State Individual Educational Program (IEP). (For issuance of a Temporary Regional Reduced Fare Permit only.)
- I am medically disabled as certified by a Physician, Psychiatrist, Psychologist (Ph.D.), Physician's Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.) or Audiologist, licensed in the State of Washington. **See Health Care Provider's Certification form on the reverse side of this application.** This agency reserves the right to contact your Health Care Provider for verification.

Applicant's Signature _____ Date _____

**Community Transit
Everett Transit
Intercity Transit
Jefferson Transit**

**Kitsap Transit
Mason Transit
King County Metro Transit
King County Ferry District**

**Pierce Transit
Skagit Transit
Sound Transit
Washington State Ferries**

For more information and additional copies of the eligibility criteria, call 206-553-3060.

Office: 201 South Jackson Street, Seattle, WA 98104-3856

BACK Regional Reduced Fare Permit – Certification of Eligibility

Applicant's Release

I hereby authorize the physician to release any information necessary to complete this certification. I understand that this information is confidential and shall not be released without my approval or a court order. I understand that the transit agency issuing this permit shall have the right and opportunity to verify my eligibility for a Regional Reduced Fare Permit. I understand that if any of the statements made on this application form are false or inaccurate, I will lose the privileges granted by the Reduced Fare Permit and be subject to criminal prosecution in accordance with Washington State Law for fraud (RCW #9A.56.020).

Please Print

Name _____
First Middle Last

Address _____
Street City State ZIP

Date of Birth _____ Phone No. _____
Area Code

Applicant's Signature _____ Date _____

This Section To Be Completed By The Following Approved Health Care Provider:

Washington State-licensed: • Physician (M.D.) • Psychiatrist • Psychologist (Ph.D.)
• Audiologist certified by the American Speech, Language and Hearing Association
• Physician's Assistant (P.A.) • Advanced Registered Nurse Practitioner (A.R.N.P.)
• **Signatures of Health Care Providers other than those above are not acceptable.**

1. This applicant must meet at least one of the criteria and conditions listed in the *Medical Eligibility Criteria and Conditions* brochure.
2. The specific Medical Eligibility Criteria number must be noted in the space provided.
3. If Section 6.4 is used, this person must be diagnosed by you as being "Acute-at-risk." The appropriate subsection (a, b, c or d) must be included along with the name and phone number of the work activity center, training or rehabilitation program in which this patient is currently a patient. **Note:** An applicant's enrollment in a drug or alcohol rehabilitation program does not, in and of itself, meet eligibility requirements.
4. An applicant's financial situation has no bearing on eligibility.

I certify that _____ meets the Medical Eligibility Criteria _____.

If Section 6.4, (a, b, c or d) enter name of qualifying program: _____

Please check the appropriate boxes:

Yes No

The disability is Temporary. Specify length of disability: _____ months. A temporary disability must be expected to last at least three months, but no longer than one (1) year.

The disability is Permanent.

This applicant requires a Personal Care Attendant if yes: temporary; permanent

Verification of Approved Health Care Provider – Please Print

Name _____ Phone No. _____

Provider or Agency Address _____

Washington State License No. _____

Signature _____ Date _____

Original signature – no photocopies or fax accepted.

I understand that if any of the statements made on this application form are false or inaccurate, I will be subject to criminal prosecution in accordance with Washington State Law for fraud (RCW #9A.56.020).