# Asotin County PTBA
# Application for Half Fare Card

If one of these applies, you are eligible for a Half Fare Card:

- You are 62 years of age or older.
- You have a Medicare Card.
- You have a disability that requires personalized assistance, attention or accommodation to ride the fixed route.

General Contact Information:

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Date of Birth: _____

E-Mail: _____

- In applying for a Half Fare Card, I agree to release information requested for the purposes of establishing my eligibility and allow the Asotin County PTBA to request confirmation from an authorizing agency.
- I understand that my Half Fare Card will entitle me to use the fixed route at half the cost of the regular fare during all hours of operation. I understand that allowing another person to use the card is fraudulent and that the card is the property of the Asotin County PTBA and may be retrieved upon expiration because of a temporary disability or for misuse.
- I hereby certify that all the statements made in this application are true representations of my eligibility to participate in the Asotin County PTBA's Half Fare Program.

_____ _____

Signature (required by all applicants) Date

To verify eligibility for a Half Fare Card you must present photo identification with:

1. One of the following Proofs of Eligibility which provides verification that shows you are eligible for or receive services under one of the following:
   - ☐ Identification card showing age 62 or older
   - ☐ Medicare Card
   - ☐ Supplemental Security Income (SSI) disability benefits
   - ☐ Social Security Disability (SSD) benefits
   - ☐ Veteran's Administration benefits at 50% or greater disability
   - ☐ Veteran's Administration non-service connected pension

**- OR –**

| STAFF USE ONLY |
| --- |
| Verified by: _____ (initials) |
| Circle one: Approved Denied |

2. Licensed Medical, Mental Health, Audiologist Verification of Disability

<u>Licensed Medical, Mental Health, Audiologist Verification of Disability</u>

Health Care Providers Name: _____
Telephone: _____
Address: _____

Patient's Name: _____

Please check all that apply:

**Section A:**

1. ____ Requires the use of a wheelchair for travel throughout the community.
2. ____ Significant difficulty in waiting for, boarding or disembarking from a standard bus.
3. ____ Difficulty standing in a moving vehicle.
4. ____ Inability to read information signs or symbols.
5. ____ Inability to hear announcements by transit operators or attendants in public transit vehicles or facilities.
6. ____ Inability to qualify for driver's license due to #____ of Section B (below).
7. ____ Substantial difficulty in effectively utilizing public transportation without special planning.

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**Section B:**

The dysfunction checked in Section A is due to the following disability: (Check all appropriate categories)

1. Visual impairment such that,
   a. ____ Vision in better eye is 20/200 or less after best correction.
   b. ____ Visual field is contracted to 10 degrees or less from a point of fixation or subtends to an angle no greater than 20 degrees.
2. ____ 50% bilateral hearing loss uncorrected by use of a hearing aid.

3. ____ Muscular-skeletal impairment such as muscular dystrophy, ontogenesis imperfeca, or sever rheumatism or arthritis of therapeutic Grade III, or anatomical State III.
4. ____ Cardiovascular impairment of functional Class III or IV.
5. ____ Respiratory impairment Class III or greater.
6. ____ Amputation of, or anatomical deformity due to vascular or neurological deficits, traumatic loss of muscle mass or tendons, or instability of:
    a. ____ both hands
    b. ____ one hand and one foot
    c. ____ one lower extremity at or above tarsal region.
7. ____ Neurological disorder due to brain dysfunction or damage to the central nervous system including cerebral palsy resulting in aberration of motor functions.
8. ____ Paralysis, incoordination, or functional motor deficit in any two limbs due to brain, spinal or peripheral nerve injury, including paraplegia, quadriplegia, hemiplegia, etc.
9. ____ Mental/emotional disability, which **substantially** limits the applicant's ability to effectively utilize public transit systems.
10. ____ Mental retardation resulting in impairment in adaptive behavior, with an IQ of two standard deviations or more below the norm, or 72.
11. ____ Epilepsy (seizure disorder) involving impairment of consciousness, which occurs more frequently than once a month despite prescribed treatment.
12. ____ Other – (specify medical disorder and resultant restrictions of mobility):

_____

**Section C:**

1. Is Condition – (check one)
    a. ____ Permanent
    b. ____ Temporary? How long? _____

_____

**Section D:**

I hereby certify, under penalty of perjury, that this application is true and correct to the best of my knowledge and that I am currently certified/licensed as indicated.

_____ _____

Physician's Signature and Title Date