



# 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 City of Lewiston 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 service hours. I understand that allowing another person to use the card is fraudulent and that the card is the property of the City of Lewiston 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 City of Lewiston'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 -

2. Licensed Medical, Mental Health, Audiologist Verification of Disability (next page)

STAFF USE ONLY

Verified by: \_\_\_\_\_  
(initials)

Circle one:  
Approved Denied

Licensed Medical, Mental Health, Audiologist Verification of Disability

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 drivers license due to # \_\_\_\_ of Section B (below).
7. \_\_\_\_ Substantial difficulty in effectively utilizing public transportation without special planning.

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, osteogenesis imperfecta, 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 an 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