# REDUCED FARE ELIGIBILITY APPLICATION

**This application is intended for people with permanent disabilities.**
**Proper documentation and photo identification are required.**

**APPLICANT INFORMATION – Please print**

______________________________________________
Last Name | First | Middle Initial | Date of Birth

______________________________________________
Street Address | Apt. # | City | Zip Code

I certify under penalty of perjury that this application is true and correct, to the best of my knowledge, and I agree to release this information to Ben Franklin Transit for statistical purposes only.

______________________________________________
Applicant or Guardian's Signature | Contact Phone Number | Date

**A photo ID, or one of the following documents, may qualify you for a Reduced Fare Pass:**

- Social Security Medicare Card
- Social Security Disability award letter with "DI" number
- Department of Vocational Rehabilitation (DVR)/Division of Developmental Disability (DDD) letter
- Washington State Handicapped Parking ID card (Permanent only)
- Written attestation from a medical/mental health care professional on their letterhead

**STOP HERE unless you are going to have a medical service provider or mental health professional complete the rest of this form so you can use it to apply for reduced fare.**

**IMPAIRMENT INFORMATION** ***(to be completed by a medical service provider or mental health professional)***

**SECTION A –** Applicant qualifies for reduced fare because of a transportation dysfunctional impairment causing: (Choose **all** that apply, then complete Sections B-D)

1. ______ Requires the use of a wheelchair to 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 conductors/operators in public transit vehicles
6. ______ Inability to qualify for driver's license due to no. ______of Section B
7. ______ Substantial difficulty in effectively utilizing public transportation without special planning or design

**SECTION B –** The dysfunction(s) checked in Section A is due to the following disability: (Choose **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 the use of a hearing aid

3. ______ Muscular-skeletal impairment such as muscular dystrophy, osteogenesis imperfecta, or severe rheumatism or arthritis of therapeutic Grade III, or anatomical State III
4. ______ Cardiovascular impairment class III or greater
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 of adaptive behavior, with an IQ of two standard deviations or more below the norm, or 72
11. ______ Epilepsy (convulsion 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 below:

______________________________________________________________________

______________________________________________________________________

**SECTION C**
I certify under penalty of perjury that this application is true and correct to the best of my knowledge, and I am licensed/certified to diagnose the permanently disabling condition(s) of this applicant:
(check one)

______ Physician/Physician Assistant
______ Rehabilitation Counselor
______ Clinical Social Worker
______ Psychologist
______ Registered Nurse (representing a medical/mental health service agency)

**SECTION D**
I have completed all sections of this application by checking the relevant information, and I recommend this applicant for reduced fares for fixed route service with Ben Franklin Transit (excludes Dial-A-Ride service).

______________________________________________________________________
Signature and Title Date

______________________________________________________________________
Agency/Business Phone Number

______________________________________________________________________
Street Address City Zip Code

Ben Franklin Transit reserves the right to make final determination of eligibility for reduced fare. Applications are for internal use only and will not be subject to public review. The issuance of a Reduced Fare Card is for the purpose of identification by the transit system only**; it is not transferable.**

*For Office Use Only:*
_____New Applicant
_____Annual Update of General Info Only
_____ Replacement # _______
DATE: ______________ CSR: ________
DATA ENTRY: ________________