Application for Regional Reduced Fare Permit for Senior and Disabled Persons

FRONT

This application is available in accessible format • Processing fee $3.00

Note: Applicants must be at least 6 years old to be eligible for a Regional Reduced Fare Permit.

For Office Use Only
ID# _____
PCA _____
☐ Temporary
☐ Permanent
Date _____

Please Print

Name _____
First Middle Last

Address _____

City _____ State _____ ZIP _____

Date of Birth _____ Phone No. _____

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.*

Permanent Permit:

☐ I am 65 years of age or older.

☐ I am providing proof of current eligibility by the Veterans Health Administration as having a disability of at least 40%.

Temporary Permit:

☐ I am providing proof of eligibility and am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability. (Applicant must show award letter.)

☐ I am presenting a valid Medicare card issued by the Social Security Administration.

☐ I am currently participating in a vocational career program with the Washington State Individual Educational Program (IEP).

☐ I am providing a Washington Department of Licensing-issued disabled parking identification in conjunction with a government-issued photo identification.

Permanent or Temporary Permit (case-by-case):

☐ I am providing a valid Regional ADA paratransit card or other supporting materials issued by (Agency) _____

ADA paratransit card/supporting materials expire(s) on _____

☐ 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 medically disabled as certified by a Physician (M.D.), Psychiatrist, Psychologist (Ph.D.), Physician's Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.), Audiologist certified by the American Speech–Language–Hearing Association, Osteopathic Physician (D.O.) licensed in the State of Washington. See ***Health Care Provider's Certification*** form on the back side of this application. This agency reserves the right to contact your Health Care Provider for verification.

Applicants Signature _____ Date _____

Regional Reduced Fare Permit — Certification of Eligibility

BACK

Applicant's Release — Please Print

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 Regional Reduced Fare Permit and be subject to criminal prosecution in accordance with Washington State Law for fraud (RCW #9A.56.020).

Name _____
First Middle Last

Address _____

City _____ State _____ ZIP _____

Date of Birth _____ Phone No. _____

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.) • Physician's Assistant (P.A.) • Advanced Registered Nurse Practitioner (A.R.N.P.) • Audiologist certified by the American Speech–Language–Hearing Association • Osteopathic Physician (D.O.) **— Signatures of Health Care Providers other than these are not acceptable.**

1. This applicant must meet at least one of the criteria and conditions listed in the ***Medical Eligibility Criteria and Condition***s 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 _____
Section, Subsection

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: _____ years _____ months. A temporary disability must be expected to last no longer than 5 years.

☐ Yes ☐ No The disability is permanent.

☐ Yes ☐ No 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. _____

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

Signature _____ Date _____

Original Signature Only — No Photocopies or FAX Accepted

Title VI Notice: All participating agencies in the RRFP program fully comply with Title VI of the Civil Rights Act of 1964 and related statutes and regulations in all programs and activities. For more information, or to obtain a Title VI Complaint Form, please contact the appropriate agency.