APPLICATION FOR REDUCED FARE AUTHORIZATION CARD

FOR OFFICE USE ONLY

Card No. ____ - ____________ Expiration ________________

Documentation

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Today's date ______________________________

TYPE OF ELIGIBILITY (Please choose one.)

Senior ❑ Youth ❑ Person with Disability ❑

APPLICANT INFORMATION (Please print.)

FIRST NAME ____ INITIAL ____ LAST NAME ____

ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

PHONE ____ BIRTH DATE ____ SIGNATURE OF APPLICANT ____

APPLICANTS WITH DISABILITY (To be completed by a qualified health or rehabilitation professional.)

➡ DURATION OF DISABILITY: TEMPORARY ❑ (UNTIL WHEN_______?) OR PERMANENT ❑

ICD-9 TYPE OF DISABILITY

10. ❑__________ Non-Ambulatory Disability

20. ❑__________ Semi-Ambulatory
21. ❑__________ Arthritis
22. ❑__________ Loss of Extremities
23. ❑__________ Cerebrovascular Accident
24. ❑__________ Respiratory
25. ❑__________ Cardiac
26. ❑__________ Dialysis
27. ❑__________ Spinal Disorder
28. ❑__________ Nerve Root Compression
29. ❑__________ Motor

30. ❑ Braces
31. ❑ Wheelchair
32. ❑ Walker
33. ❑ Scooter
34. ❑ Cane

ICD-9 TYPE OF DISABILITY

40. ❑__________ Mental Disabilities

41. ❑__________ Developmental Disabilities
42. ❑__________ Adult Mental Retardation
43. ❑__________ Autism
44. ❑__________ Neurological Disabilities
45. ❑__________ Mentally Disordered Disability

50. ❑__________ Hidden Disabilities
51. ❑__________ Visual Disabilities
52. ❑__________ Auditory Disabilities
53. ❑__________ Seizure Disorder

60. ❑__________ Other Disabilities (List)

Additional Comments ⬇

ALL INFORMATION PROVIDED IS CLASSIFIED AS CONFIDENTIAL.

CERTIFYING HEALTH OR REHABILITATION PROFESSIONAL (Please print.)

NAME ____ TITLE ____ LICENSE # ____

AGENCY OR OFFICE ____ PHONE ____

ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

I certify, the the best of my knowledge, the applicant has been diagnosed with a disabling condition.

SIGNATURE OF PROFESSIONAL ____ DATE ____

PLEASE MAKE SURE APPLICATION IS COMPLETED, SIGNED AND DATED.