This application is available in accessible format.

Application for Regional Reduced Fare Permit For Senior Citizens and Disabled Persons

For Senior Citizens and Disable Persons – Processing Fee $3.00

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

Please Print

Name _____
First Middle Last

Address _____
Street City State ZIP

Date of Birth _____ Phone No. _____
Area Code

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.**

☐ I am 65 years of age or older.

☐ I am providing proof of eligibility and am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability. (For issuance of a Temporary Regional Reduced Fare Permit only.)

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

☐ I am presenting a valid Medicare card issued by the Social Security Administration. (For issuance of a Temporary Regional Reduced Fare Permit only.)

☐ I am providing a valid Regional ADA paratransit card, issued by_____(Agency)

This ADA paratransit card expires _____.

☐ I am providing a valid ADA paratransit card from outside the region. (For issuance of a Temporary Regional Reduced Fare Permit only.)

☐ 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 currently participating in a vocational career program with the Washington State Individual Educational Program (IEP). (For issuance of a Temporary Regional Reduced Fare Permit only.)

☐ I am medically disabled as certified by a Physician, Psychiatrist, Psychologist (Ph.D.), Physician's Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.) or Audiologist, licensed in the State of Washington. **See Health Care Providers Certification form on the reverse side of this application**. This agency reserves the right to contact your Health Care Provider for verification.

Applicant's Signature _____ Date _____

Community Transit	**Jefferson Transit**	**Metro Transit**	**Sound Transit**
Everett Transit	**Kitsap Transit**	**Pierce Transit**	**Washington State Ferries**
Intercity Transit	**Mason Transit**	**Skagit Transit**	

For more information and additional copies of the eligibility criteria, call 206-553-3060.
Office: 201 South Jackson Street, Seattle, WA 98104-3856

Regional Reduced Fare Permit – Certification of Eligibility

Applicant's Release

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

Please Print

Name _____
First Middle Last

Address _____
Street City State ZIP

Date of Birth _____ Phone No. _____
Area Code

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.)
• Audiologist certified by the American Speech, Language and Hearing Association
• Physician's Assistant (P.A.) • Advanced Registered Nurse Practitioner (A.R.N.P.)

Signatures of Health Care Providers other than those above are not acceptable.
Instructions:

1. This applicant must meet at least one of the criteria and conditions listed in the *Medical Eligibility Criteria and Conditions* 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 requirement.
4. An applicant's financial situation has no bearing on eligibility.

This section is to be completely filled out by the approved Health Care Provider.

I certify that _____ meets the Medical Eligibility Criteria _____
(Applicant) **(SECTION & SUBSECTION Number)**

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: _____months. A temporary disability must be expected to last at least three months, but no longer than one year.
☐	☐	The disability is Permanent.
☐	☐	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. _____

Signature_____ Date_____

Original signature – no photocopies or fax accepted.

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