Application for Visalia Transit Senior/Disabled Identification Card For Fixed Route Service

INSTRUCTION SHEET

Thank you for your interest in Visalia Transit's Senior/Disabled ID Card program. This program provides a reduced fare on Visalia Transit services for eligible customers. This application is only for seniors and/or persons with disabilities.

THE APPLICATION PROCESS

1. Complete and sign the front of the application.
2. Have your physician or licensed health care professional who is treating you for the qualified disability complete pages 3-4 of the application.

RETURNING THE APPLICATION

Return application with certifications by APPOINTMENT ONLY:

Call:
Visalia Transit
(559) 713-4100

Appointment Location:
Visalia Transit Center
425 E Oak Ave. Ste. 301

BRING THE FOLLOWING WHEN YOU COME IN FOR YOUR APPOINTMENT

1. Your completed application (with Licensed Professional's Statement of Medical Disability Eligibility, if Required.)
2. Your current state or government –issued photo ID that shows your date of birth (state driver's license, state ID cards, or passport). **Photocopies will NOT be accepted.**

NOTIFICATION OF APPROVAL

Visalia Transit will notify you if your application is approved within 15 business days of receiving your application.

Until your application is approved, you must purchase the regular full fare.

Visalia Transit reserves the right to make final determination of eligibility of disabled identification cards. Applications are for internal use only and will not be subject to public review. Should an application be denied, an appeal may be filed with Visalia Transit or you may resubmit your application.

Inaccurate or incomplete information on the application, failure to provide required identification, or inability to verify physician/licensed health care provider's certification may result in the inability to issue the Visalia Transit Disabled ID Card within the 15 days.

APPLICATION FOR SENIOR/DISABLED IDENTIFICATION CARD FOR FIXED ROUTE SERVICE

FOR OFFICE USE ONLY
Certification Date: ____/____ /____
Expiration Date: ____/____ /_____
Issued by: _____

Name:

Visalia Transit will notify you in writing if your application has been **approved within 15 business days** of receiving your application. **Once your application has been completed, you may call to make an appointment to turn in your application and have your picture taken at the Visalia Transit Center**. Visalia Transit reserves the right to make a final determination of eligibility for disabled identification cards. Applications are for internal use only and will not be subject to public review. Should an application be denied, an appeal may be filed with Visalia Transit or the applicant may resubmit. A parent or legal guardian must sign for applicants under 18 years of age.

This Section To Be Completed By Applicant

( ) MR.
( ) MRS.
( ) MS.

_____ _____ _____ _____/_____/_____
Last Name First Name Middle Initial Date of Birth

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ (_____)_____
E-Mail Address Phone Number

1. Check the Appropriate Box Below

( ) NEW CARD: If you have not had a Visalia Transit Disabled ID Card. You must have your physician or licensed health care provider complete and sign pages 3-4. (If required)

( ) RENEWAL CARD: If your Visalia Transit Disabled ID Card is expired. You must have your physician or licensed health care provider complete and sign pages 3-4. (If required)

( ) REPLACEMENT CARD : If your Visalia Transit Disabled ID Card was lost or stolen. Replacement cost is $2.00.

ID Card #

2. I am applying for a Visalia Transit Disabled ID Card on the following basis. (Please check all that apply.)

( ) I am 65 years of age or older. (Must show valid government-issued photo ID that shows your date of birth.)
Licensed Professional's Statement NOT required (MAKE A PHOTOCOPY OF ID)

( ) I am providing proof of current eligibility by Veteran's Administration as having a disability of at least 40%
Licensed Professional's Statement NOT required (MAKE A PHOTOCOPY OF ID)

( ) I am presenting a valid Medicare card issued by the Social Security Administration.
License Professional's Statement NOT required (MAKE A PHOTOCOPY OF CARD)

( ) I am providing a valid ADA paratransit card from outside the region. (For issuance of a Temporary Visalia City Transit Disabled ID Card) **(MAKE A PHOTOCOPY OF ID)**

( ) 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 California. Visalia Transit reserves the right to contact your health care provider for verification.

3. Read and Sign/Date

I certify to the best of my knowledge that the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

I understand that my Visalia Transit Disabled ID Card is not transferable to other persons and that Visalia Transit reserves the right to determine qualifications for issuing cards in accordance with the terms and conditions listed on the application instruction sheet. I understand that my Visalia Transit Disabled ID Card is valid until the date printed on the card and that I must reapply at the time if I wish to continue my eligibility with the Visalia Transit Disabled ID Card program. I understand that upon boarding the bus, I must show my Visalia Transit ID Card to the driver.

I understand that the information on this application will be kept confidential by the professionals involved in evaluating my eligibility. I understand that Visalia Transit will contact the physician or licensed health care provider on the back of this form to verify my qualifying disability. **I authorize the certifying physician or licensed health care provider to provide all information needed to Visalia Transit in determining my eligibility for the Visalia Transit Disabled ID program.**

*** I have read and understand that until my Visalia Transit Disabled ID Card is approved, I will need to purchase the regular adult fare. (A parent or legal guardian must sign for applicant under 18 years of age.)**

_____ _____

*** Original** Signature (stamped/copies/faxed signatures **NOT** accepted.) Date of Signature

BULE INK ONLY

3. Return This Application

Call to make Appointment :

Visalia Transit
(559) 713-4100

Appointment Location :

Visalia Transit Center
425 E. Oak Ave. Suite 301
Visalia, CA 93291

LICENSED PROFESSIONAL'S STATEMENT OF MEDICAL DISABILITY ELIGIBILITY

Print Applicant's Name: _____

To qualify for Visalia Transit Disabled ID Card program your client/patient listed on the front of this application must have physical or mental condition(s) that falls within the medical eligibility criteria listed below that substantially limits major life activity such as caring for one's self, walking, seeing, hearing, speaking, breathing, learning, and or working. Conditions which do not qualify are: pregnancy, obesity, acute or chronic alcoholism or drug addiction, and contagious diseases which pose a danger to other passengers.

THIS SECTION TO BE COMPLETED BY ONE OF THE FOLLOWING:

( ) Physician ( ) Chiropractor ( ) Health Care Provider ( ) Physical Therapist

( ) Rehabilitation Counselor ( ) Other Licensed Professional _____

Is the disability permanent?

( ) Yes

( ) If **NO, HOW LONG** do you expect disability to last? _____

*** NOTE:** if a disability is temporary, it must last for at least 90 days to be eligible for a reduced fare.

Please check **ALL** that apply

( ) Disabled Veteran

( ) NON-AMBULATORY: An individual is unable to walk and requires the use of a wheelchair or other mobility device.

( ) SEMI-AMBULATORY: An individual has a chronic condition which substantially limits the ability to walk, or is unable to walk without the use of a caliper leg brace, walker or crutches.

( ) AMPUTATION: An individual has an amputation of one or both hands, arms, feet or legs.

( ) STROKE: An individual has substantial functional motor deficits in any two extremities, loss of balance and/or impair ments three months post stroke.

( ) NEUROLOGICAL CONDITIONS OTHER THAN STROKE: An individual has difficulty with coordination, communication, social interaction, and/or perception from a brain, spinal, or peripheral nerve injury or illness, has functional motor deficits, or suffers manifestations that significantly reduce mobility. A specific diagnosis is required._____

( ) PULMONARY OR CARDIAC CONDITIONS: An individual has a pulmonary or cardiac condition resulting in marked limitation of physical functioning and dyspnea during activities such as climbing steps and/or walking a short distance. If diagnosis is asthma, please state whether: a) individual has been on systemic medication for the immediate past six months, or b) individual has been required to use fast-acting inhaler for three or more episodes per week for immediate past six months. A specific diagnosis is required. _____

( ) BLIND OR LOW VISION: An individual is legally blind, whose visual acuity in the better eye, with correction, is 20/20 or less, or who has tunnel vision to 10 degrees or less from a point of fixation or so the widest diameter subtends an angle no greater than 20 degrees. An individual has low vision, and whose visual acuity is the range of 20/70 to 20/200 with best correction.

( ) DEAF OR HARD OF HEARING: An individual with a pure tone average greater than 70 dB in both ears, regardless of use of hearing aids.

( ) EPILEPSY: An individual has had at least one tonic-clonic seizure within the past four months.

( ) DEVELOPMENTAL OR LEARNING DISABILITIES: An individual has significant learning, perceptual and/or cognitive disability. Some conditions are excluded from eligibility such as attention deficit disorder (ADD) and ADHD. A specific diagnosis is required. _____

Cont. on Next Page

( ) MENTAL ILLINESS: An individual whose mental illness includes a substantial disorder of thought, perception, orientation, or memory that impairs judgment and behavior. A specific diagnosis is required.

_____

( ) CHRONIC PROGRESSIVE DEBILITATING CONDITIONS: An individual who experiences debilitating diseases, autoimmune Deficiencies, or progressive and uncontrollable malignancies, and of which are characterized by fatigue, weakness, pain, and/or changes in mental status that impairs mobility. A specific diagnosis is required.

_____

( ) OTHER DISABILITY (Please explain):

_____
_____
_____
_____

I certify that I am a legally licensed professional by the State of California, I am currently treating the client/patient listed on the front of this application for a qualifying disability, the applicant is disabled as defined by the above criteria, and the information I have provided is true and correct **under penalty of perjury** according to the laws of the State of California.

_____ _____

License Professional's Name (Printed) Licensed Professional's License # (**REQUIRED**)

_____ _____

Signature (MUST BE AN ORIGINAL— Copied, Faxed, and/or Stamped NOT ACCEPTED. **BLUE INK ONLY**) Date

_____ (_____)_____

Address/Suite/City, State, Zip Code Phone Number