



# Application for Reduced Fare Permit

## For Senior and Disabled Persons

(this application is available in accessible format)

For Office Use Only	
ID#	
PCA	
<input type="checkbox"/> Temporary	
<input type="checkbox"/> Permanent	
Date	

**Please Print**

**Name**

First
Middle
Last

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**Address**

Street
City
State
Zip

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**Date of Birth**

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**Phone**

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Include Area Code

**Please read the applicant section of the *medical Eligibility Criteria and Conditions* brochure before completing this application.**

I am applying for a Reduced Fare Permit on the following basis. **Please check only one.**

- I am 65 years of age or older
- I am providing proof of current eligibility and receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability. (For issuance of a Temporary Reduced Fare Permit only)
- I am providing proof of current eligibility by the Veteran's 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 Reduced Fare Permit only)
- I am providing a valid ADA paratransit card, issued by \_\_\_\_\_ Agency  
This ADA paratransit card expires \_\_\_\_\_
- I am providing a valid Puget Sound ORCA Regional Reduced Fare Permit issued by \_\_\_\_\_ Agency
- 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 Reduced Fare Permit)
- 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.R) or Audiologist, licensed in the State of Washington. **See Health Care Provider's Certification form on the reverse side of this application.** This agency reserves the right to contact your Health Care Provider for verification.
- I am providing evidence of an Individual with Disabilities Parking Privilege.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**For more information and additional copies of the eligibility criteria, call 509-525-9140.**

**Office: 1401 W. Rose Street, Walla Walla, WA 99362**

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

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

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 requirements.*
4. An applicant's financial situation has no bearing on eligibility.

I certify that \_\_\_\_\_ meets the Medical Eligibility Criteria \_\_\_\_\_

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 (1) 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).*