



Cedar Rapids Transit Fixed-Route Bus Service Half Fare Application

APPLICANT'S PERSONAL INFORMATION:

Name:	
Address:	
City/State/Zip:	
Phone Number:	

Please select one of the following choices:

- I am 65 years of age or older and have provided a copy of my driver's license; passport; state-issued non-driver's ID; or Military ID.
- I have provided a copy of my valid Medicare Card issued by the Social Security Administration. (Note: Social Security Award Letters and Medicaid Cards **are not** accepted as proof for half fares).
- I have provided a copy of a Half Fare Card from another fixed-route transit system.
- I am disabled. (Note: If you select this choice, you **must** complete the back page of the application).

Applicant's Signature: _____	Date: _____
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CERTIFICATION AND PROOF OF DISABILITY:

The following agencies are authorized to certify disability eligibility:

Abbe Center for Community Health
ARC of East Central Iowa
Area Payee Service
Cedar Valley Community Support Services
Crest Services
Discovery Living
Evert Connor Center for Independent Living
Goodwill Industries

Horizons
Iowa Department for the Blind
Iowa Vocational Rehabilitation
Limitless Potential Inc.
Linn County MHDD
Linn County Veteran Affairs
Linn Haven
Options of Linn County
REM Iowa



Cedar Rapids Transit Half Fare Application Disability Certification

The applicant, _____, is applying to participate in the Cedar Rapids Transit Half Fare Program, which requires proof of a disability. I am familiar with the applicant's current health status and medical condition and I hereby certify that: (check all that apply):

- The applicant has a mental or physical impairment that substantially limits one or more major life activity.
- The applicant is unable to use mass transit services as effectively as other individuals because of illness, injury, age, congenital malfunction or other disability.

The condition is expected to last more than 90 days: Yes No

The condition is expected to last: Permanently Temporarily*

*Temporary disability is estimated to last until _____
(Approximate Date)

Comments Regarding Applicant's Disability: _____

Certifying Doctor, Health Care Professional or Provider Agency

I hereby certify that I have personal knowledge of the applicant's current medical condition and that all statements made in this certification form are true and correct.

Name	
Title	
Organization	
Address	
Phone	

(Signature of Doctor, Health Care Professional or Agency Employee)

(Date)

CONSENT TO RELEASE INFORMATION: I hereby authorize the release of the requested health and personal information.

(Signature of Applicant)

(Date)