FREE FARE PROGRAM FOR PERSONS WITH DISABLITIES:
CORRECTION FOR SECTION V

I. ABOUT THE PROGRAM

If you are an individual with a disability, you may be eligible to participate on our Free Fare Program for Persons with Disabilities. The program allows persons with certain disabilities to ride Radford Transit's fixed routes for free. All of our vehicles are wheelchair accessible.

II. WHO QUALIFIES

The Federal Transit Administration specifies that people with one or more of the following circumstances qualify:

- Receiving Medicare benefits for any reason other than age
- Mobility Impairment
- Visual Impairment
- Hearing Impairment
- Ambulatory disability/Physical Impairment
- Amputation
- Intellectual Disability and/or other organic mental capacity impairment

If you do not have one of these conditions, you are not eligible for the Disabilities Free Fare Program. Read the entire form carefully before you apply.
Eligibility is not based on income level or employment status. The following conditions are not eligible for *reduced/free* fare: pregnancy, obesity, drug or alcohol addiction.

III. HOW TO OBTAIN A DISABLITY *REDUCED/FREE* FARE ID CARD

1. Complete Parts I-IV of the application
2. Have your health care professional ("Certifier") complete Part V of the application. You, the applicant, are responsible of any fee that your Certifier may charge.
3. All applicants must attach, one 2" x 1 ½ "(passport type) color photo.
4. Applications are accepted through mail only (no fax or photocopy).
5. If you are approved, your ID card will be mailed to you free and is valid for 1 year from date of issue or August 31st of each year. There is a replacement fee of $5.00 if the card is lost, damaged, or stolen.

IV. CERTIFICATION PROCESS

1. The City of Radford may contact the certifying health care professional to verify the accuracy of the information provided.
2. The City of Radford reserves the right to make the final determination as to an applicant's eligibility.
3. If your application is denied, you will be notified and given information on how to appeal the decision.
4. The application must be filled out completely for processing to occur. Incomplete applications will be returned.

V. MEDICARE RECIPIENTS: CORRECTION

If you have a valid Medicare card (and you are NOT 65 years of age or older) you may ride for reduced/free fare by:

Applying for a Radford Transit issued ID card by completing Parts I – IV of this application and attaching a copy of your Medicare card, a copy of your photo ID, and a color photo of yourself. When you ride the bus, present your Radford Transit issued photo ID card.

RADFORD TRANSIT

Free Fare Application for Individuals With Disabilities

For Office Use Only

ID#_____ Expiration Date:_____

Date Issued: _____
Approved by:_____ Date: _____
Denied by:_____ Date: _____

PART I. GENERAL INFORMATION

_____ Female ___ Male ___

Name: Last First Middle Initial

Street Address Apt./Bldg#

City State Zip Code

_____
E-Mail Address (optional)

Mailing Address (if different from above)

Home Phone: _____ Work Phone: _____

Social Security Number: **000-00-** _____ Date of Birth:_____
(Last 4 digits only)

Do you currently have a Radford Transit Fare Card? _____ No ____ Yes ID#:_____

Do you currently have a Medicare Card? ____ No _____ Yes **(If Yes, it is not necessary to fill out Part V of this application.)**

PART II. PHOTOGRAPH REQUIREMENTS

Print your name on the back of the photo, then attach the photo here

Attach a color photo to the box at left.

Photo should be no smaller than 2" x 1 ½"

Photo must be from the shoulders up.

Face must be clearly visible (no sunglasses, or hats that obstruct the face).

Photos cannot be returned

PART III. TERMS AND CONDITIONS

Free Fare card must be shown to the operator when boarding the bus.

Radford Transit reserves the right to confiscate a Free Fare card that has been used improperly or expired. A confiscated card will not be returned or replaced.

In the event your card is lost or stolen, replacement cards are $5.00 each. No additional cards will be issued after the third one until a review of your replacement history is conducted by a Radford Transit representative. If a replacement card is not issued, you may reapply upon the expiration date of your card.

PART IV. APPLICANT CERTIFICATION

I agree to the terms and conditions as set forth above.

I certify to the best of my knowledge and ability, the information in this application is true and correct. I hereby authorize permission to the licensed health care professional to release any relevant information for the purpose of evaluating my eligibility to participate in the Free Fare Program.

Applicant Signature: _____ Date: _____

If this application was completed for you by another person, please provide the following information.

Name: _____ Daytime Phone: _____

Address: _____

Agency or Clinic (if applicable): _____

Relationship to Applicant: _____

Signature: _____ Date: _____

If you have any questions concerning the application or the service, please contact the Transit Coordinator at (540) 267-3188.

1. **Please do not fax the application – we can only accept the original.**
2. **Incomplete applications will be returned.**
3. **Please allow a minimum of 10 business days for processing.**

Mail completed application to:
Radford Transit Coordinator
10 Robertson Street
Radford, VA 24141

PART V. PROFESSIONAL CERFIFICATION

INFORMATION ABOUT THE APPLICANT'S DISABILITY

This section (pages 3-5) must be completed by a licensed health care professional.
Customer medical records or income information are not accepted with application.

Please mark all conditions that affect the applicant's ability to use mass transit.

Diagnosis:

☐ **Blindness –** There is central visual acuity of 20/200 or less in both eyes with the use of correcting lenses. Each eye which, accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle of greater than 20 degrees, shall be considered as having central acuity of 20/200 or less.

☐ **Hearing Impairment** – With hearing aids, hearing in each ear is NOT restored to one of the following minimum levels:

☐ **Average hearing** threshold sensitivity for air conduction of 90 decibels or greater, and for bone conduction to corresponding maximum levels, determined by the simple average of hearing threshold levels at 500, 1,000 and 2,000 HZ; or

☐ **Speech discrimination scores** of 40 % or less in each ear.

☐ **Non- Ambulatory Disability/Disorder of Gait**
From whatever cause, the applicant is unable to move about without a walker, wheelchair, scooter, crutch(es), cane or other mobility/ambulation aid at all times. The word "unable" is used in its literal sense. The fact that one of these mechanical aids facilitates movement is not sufficient.

☐ **Arthritis** – Therapeutic Grade III or worse, Functional Class III or worse, Anatomical Grade III or worse.

☐ **Amputation** – Traumatic loss of muscle mass or tendons or x-ray of bony or fibrous ankyloses, joint subluxation or instability of hands, one hand and one foot, or amputation at or above tarsal region.

☐ **Stroke**- Causing Pseudo bulbar, Palsy, sustained functional motor deficit of gross/dexterous movement or gait, ataxia two extremities.

The applicant is unable to move about without use of the following aid:

☐ Wheelchair ☐ Scooter ☐ Cane ☐ Crutch(es) ☐ Walker

Other ambulation aid (describe): _____

Free Fare Application for Individuals With Disabilities

Diagnosis (continued):

☐ **Respiratory** – Class III or greater

☐ **Cardiac**- Vascular impairment of Functional Class III or IV and Therapeutic Class C, D, or E

☐ **Dialysis** – Individuals who require kidney dialysis to live

☐ **Chronic Progressive Debilitating Disorders:** Disease that are characterized by chronic symptoms such as fatigue, weakness, weight loss, and change in mental status which interfere in daily living activities and significantly impair mobility.

- Progressive and uncontrollable malignancies
- Advanced connective tissue disease such as Lupus Erythematosus, Scleroderma or Polyarthritis Nodosa.
- Symptomatic HIV (AIDS or ARC) in CDC defined clinical group IV.

☐ **Neurological Impairments:** As contained in Disability Evaluation under Social Security Publication.

☐ Intellectual Disability and/or Other Organic Mental Capacity Impairment [The opinion must be given by a physician, medical social worker, or mental retardation service agency.] The scores specified below refer to those obtained on the W.A.I.S./ and are used only for reference purposes. Scores obtained on other standardized individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning:

☐ The person is mentally incapacitated such that he or she is dependent upon others for personal needs (e.g., toileting, eating, dressing, or bathing) **AND** is unable to follow directions, such that the uses of standardized measure of intellectual functioning is precluded; or

☐ Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 59 or less; or

☐ Based on a valid verbal, performance, or full-scale IQ test, the person has and IQ of 60 to 70 **AND** either (a) is unable to perform routine repetitive tasks; or (b) has another mental capacity impairment that imposes additional and significant limitations of mobility or gait.

☐ **Other Organic Mental Capacity Impairment** – The person experiences mental incapacity due to an organic cause(s) that imposes significant limitations of ambulation or gait.

I estimate that the duration of the applicant's disability(ies) will be:

☐ Permanent
☐ Temporary (☐ 3 months, ☐ 6 months, ☐ 9 months)

Does the applicant's disability require that he or she travel with an attendant?

☐ Yes ☐ No ☐ Sometimes ☐ Other (please specify) _____

Free Fare Application for Individuals With Disabilities

Application with illegible or incomplete information will be returned.
(Please use medical office stamp)

Person completing certification: _____

Professional Title: _____

Business Address: _____

Clinic or Agency: _____

Business Telephone: _____

I verify that the information provided for certification is true and correct.

_____	_____	_____
Signature	Printed Name	Date

If you have any questions concerning the application or the service, please contact the Transit Coordinator at (540)731-3603.

1. **Please do not fax your application – we can only accept an original**
2. **Incomplete application will be returned**
3. **Please allow a minimum of 10 business days for processing**

Mail Completed applications to:
Radford Transit Coordinator
10 Robertson St.
Radford, VA 24141