

BACK

Regional Reduced Fare Permit – Certification of Eligibility

Applicant’s Release – Please Print

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).

Name _____
First Middle Last

Address _____
Street City State Zip

Date of Birth _____ Phone No. _____

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 these 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 Edibility 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 long than one (1) year.

Yes No The disability is permanent.

Yes No 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 Only – no photocopies or fax accepted

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