Janesville Transit System Half-Fare Program Instructions

Thank you for your interest in obtaining a Janesville Transit System Half-Fare ID card. This program offers discounted fixed-route bus fare to qualified individuals. There are three categories used to determine eligibility:

1) Individual is age 65 or over (with proof of age).
2) Individual is currently covered under Medicare (Medicaid is ***not*** applicable).
3) Individual has a qualifying physical or mental impairment (see page 2 of application for details).

THE APPLICATION PROCESS:

All applicants must complete ***ONE*** of the following**:**

1. **If you are age 65 or older:**
    a. Complete and sign page 1 of the application.
    b. Provide photo ID with proof of age.

2. **If you are covered under Medicare:**
    a. Complete and sign page 1 of the application and bring your current Medicare ID Card.
    b. Provide photo ID.

3. **If you are an individual with a disability** under age 65:
    a. Complete and sign page 1 ***AND*** have a licensed medical professional complete page 2 of the application.
    b. Provide photo ID.

Bring your completed application to one of the following locations:

- Transit Services Center: 101 Black Bridge Road M-F 8am-4:00pm

Please note: The following will negate the application:

- Failure to provide photo identification.
- Inaccurate or incomplete information on the application.
- Lack of medical verification on page 2 of application (only required if applying as an individual with a disability).

There is no cost to the applicant for the initial Half-Fare ID card, however *if the card is lost or stolen, a replacement card will be issued at a cost of $3.00*. Janesville Transit System Half-Fare ID Cards are to be used *exclusively* by the individual named on the card. *Allowing others to use it is prohibited and will result in the immediate loss of eligibility.*

Any questions or concerns regarding the Half-Fare Program, please call the Janesville Transit System at 608-755-3150.

Janesville Transit System Half-Fare Program Application

For Office Use Only

Date Card Issued: _____ Date Card Renewed: _____ Expiration Date: _____

Comments: _____ Staff Initials: _____

_____
Last Name First Name Middle Initial

_____
Street Address Apt. #/Lot #

_____
City State ZIP Code Area Code & Phone Number

____/____/____ EMAIL: _____
Month Date Year of Birth

Check the appropriate box and sign below:

- ☐ I am age 65 or older. (Provide photo ID with proof of age.)
- ☐ I am currently covered under Medicare (bring Medicare card and photo ID with you).
- ☐ I have a physical or mental impairment, which meets the FTA definition (609.3) of a person with a disability, as listed below. (Licensed Medical Professional must complete page 2 of application.)

"*Handicapped persons* means those individuals who, by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected". *Disability* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". Major life activities include, but are not limited to caring for one's self, performing manual tasks, walking, seeing, hearing, breathing, learning, and work.

I certify that, to the best of my knowledge, the information given on this application is true and accurate. I understand that JTS will rely upon this information when determining eligibility for the Half-Fare Program. I understand that providing false or misleading information will result in my eligibility being revoked. Allowing individuals, other than myself, to utilize this card will also result in revocation.

I hereby authorize the release, either verbally or in writing, of any disability-related medical information to JTS. I understand that this information may be used in conjunction with this application when determining my eligibility for the Half-Fare Program thru JTS, and will not be released without my written authorization.

Applicant's Signature: _____ Date: _____

Applicant's PRINTED Name:_____

This page MUST be Completed by Treating Physician or Licensed Health Care Provider(State-issued Medical License)

To qualify for the JTS Half-Fare Program, your patient (listed above) must have a physical or mental impairment that falls within the eligibility criteria listed below. Certain conditions do not qualify, i.e. pregnancy, obesity, drug/ alcohol addiction, controlled epilepsy.

Please check all that apply.

A. Non-Ambulatory:

☐ 1. Impairment which requires individual to use a wheelchair or similar mobility device.

B. Semi-Ambulatory:

☐ 1. **Arthritis**–American Rheumatism Association may be used as a guideline for the determination of disability; Therapeutic Grade III, Functional Class III, Anatomical State III, or worse is evidence of arthritic disability.

☐ 2. **Loss of Extremities**–Anatomical deformity of or amputation of hand(s) and/or feet, or loss of major function.

☐ 3. **Cerebrovascular Accident**–Ongoing debilitating effects following occurrence of CVA, or effects of Cerebral Palsy.

☐ 4. **Cardio-pulmonary**–serious loss of heart or lung reserves as shown by X-ray, EKG, or other tests and in spite of medical treatment, there is breathlessness, pain, or fatigue.

☐ 5. **Dialysis**–individual who must use a kidney dialysis machine to sustain life.

☐ 6. **Other**

_____
(Diagnosis)

How does this affect mobility?

_____

C. Hearing Impairment:

☐ 1. Legally Deaf–Hearing impairment that is bilateral and not correctable by hearing aid.

D. Visual Impairment:

☐ 1. **Legally Blind**–Visual Impairment that is bilateral and not correctable with lenses.

☐ 2. **Contraction of Visual Field**–Persons whose widest diameter of visual field subtends an angular distance of 20 degrees, or less than 10 degrees from point of fixation.

☐ 3. **Low Vision**–An individual has low vision, and whose visual acuity is in the range of 20/70 to 20/200 with best correction.

E. Cognitive Impairment:

☐ 1. **Developmentally Disabled**–Cognitive disability that originates before age 18.

☐ 2. **Adult Intellectual Disability**

☐ 3. **Autism**–Monotonously repetitive motor behavior with severe withdrawal, inappropriate response to stimuli, or very inadequate social relationships.

☐ 4. **Schizophrenia**

☐ 5. **Organic Brain Syndrome/Bi-Polar**–Cognitive disturbance that requires boarding or home care, funded work activity or workshop.

F. Neurological Disabilities:

☐ 1. **Cerebral Palsy**–Impairment not controlled with medication.

☐ 2. **Multiple Sclerosis**–Impairment not controlled with medication.

☐ 3. **Epilepsy**–Grand Mal or Psychomotor; Persons who are seizure-free for period of six months do not qualify.

_____ Applicant's Impairment ***DOES NOT MEET*** any of the functional limitations listed above. Therefore, I cannot certify that the applicant's impairment meets the eligibility criteria for receiving a JTS Half-Fare Program ID Card.

Please Print or Type: All Information in this box MUST be provided by treating physician or licensed health care provider (State-issued Med Lic).

_____
Physician's/Health Care Provider's Name — State & Medical License # (Required)

_____
Office Address — City — State — ZIP

_____
Area Code + Phone Number — Area Code + FAX Number

I certify that the applicant listed above is disabled as defined by the above criteria, and that the information I have provided is true and correct. I am currently treating the applicant for the disability(s) indicated above.

_____
Authorized Signature — Date