HALF FARE PROGRAM – APPLICATION

Cheyenne Transit Program

322 West Lincolnway, Cheyenne, WY 82001
Phone: (307) 637-6253 • Fax: (307) 637-6550

INFORMATION & ELIGIBILITY

The Federal Transit Administration requires transit agencies receiving federal funding to offer a fixed route half fare program to seniors, people with disabilities and individuals with Medicare cards. People with disabilities for this purpose are defined by FTA as;

> *"those individuals who, by reason of illness, injury, age, 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."*

Senior citizens are defined as those individuals age 60 and over.

Exclusions to the half fare eligibility include; pregnancy, obesity, acute or chronic alcoholism or drug addiction, contagious diseases and temporary disabilities with a duration of less than 90 days.

Half fare cards are valid for 90 days and up to 3 years. Any fees charged for the completion of certification forms are not the responsibility of the Cheyenne Transit Program. The Cheyenne Transit Program reserves the right to verify certification forms. Incomplete forms will not be accepted.

PROCEDURE

Complete the Half Fare Application.

Submit completed application to the Cheyenne Transit Program, 322 West Lincolnway, Cheyenne, WY 82001.

If you are a senior citizen, age 60 or over, have a current Medicare card or are a veteran with a VA disability rating of 50%, you must complete the first page of this application. Bring identification with the proof of age, Medicare card and VA documentation rating to the Cheyenne Transit Program (322 West Lincolnway).

If applying as a person with a disability, complete Patient/Applicant Release portion of the Physician Certification form and submit to a licensed physician for certification. The physician will return the certification to the Cheyenne Transit Program. Applications will not be accepted, if not received directly from the physician.

Once completed application has been received, we will notify you by mail

PHYSICIAN

Complete all items in section marked "Physician Certification."

Submit Physician Certification form direct to: Cheyenne Transit Program
322 West Lincolnway
Cheyenne, WY 82001

This form is available in large print and in Spanish upon request.

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APPLICANT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth (MM/DD/YY) | Male | Female | Phone ( ) -

Street Address | Apartment/Unit #

City | State | Zip Code | Last 4 of SS #

QUALIFYING INFORMATION

To be eligible for a Cheyenne Transit Program Half Fare you must meet one or more of the eligibility conditions below.
Check all that apply.

☐ Senior (Age 60 and over): Bring application, photo ID and proof of age to the office.

☐ Medicare Recipient: Bring application, photo ID and copy of Medicare card to the office

☐ Disabled Veteran: Bring documentation of VA disability rating of 50% to the office.

☐ Certified by another transit agency: (Temporary card only)

Agency Name:________________________________ Expiration Date:_________________

City and State Issuer:____

☐ Curb to Curb Eligible: Expiration Date: _____________________

☐ I have disability and am unable, *without special facilities* or *special planning or design*, to utilize *public transportation and services as effectively as persons who are not so affected.* Please state disability and explain how it affects your ability to utilize public transportation and have your physician complete attached certification:

____

____

____

I understand that information provided is for the purpose of determining eligibility and that all information will be kept confidential. I have read and understand all half fare program information and affirm that the information provided is true and complete. I understand that fraud or abuse will result in confiscation of the card and termination of my eligibility.

____ ____________________________
Signature of Applicant Date

Official Use Only:	☐ Eligible ☐ Ineligible	☐ Temporary ☐ Permanent	Expiration Date: __________	Aprv'd by: _______ Date: ___________	Issued by: __________ Date: ___________

HALF FARE PROGRAM – PHYSICIAN CERTIFICAITON

Cheyenne Transit Program

Phone: (307) 637-6253 • Fax: (307) 637-6550

PATIENT/APPLICANT RELEASE

I authorize Dr.______________________________ to complete this application and verify my disability, to the Cheyenne Transit

Name: ____

Program: ______________________________________

Birthdate: ____________________Date: ________________

Signature: _____________________________________

PHYSICIAN CERTIFICATION

Physician Name: _________________________________

Physician License #: ______________________________

Telephone Number: _______________________________

Address: ____

People with disabilities are defined by FTA as "those individuals who, by reason of illness, injury, age, 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."

Exclusions include: Pregnancy, obesity, acute or chronic alcoholism or drug addiction, contagious diseases, or temporary disabilities with duration of less than 90 days. To qualify for the Reduced Fare Program, individuals must have a physical or mental condition that falls within the eligibility criteria listed at right. Check all that apply.

	Yes	No
Does disability affect one or more major life activities? Explain: ____________ ______________________________	☐	☐
Does patient/applicant meet on or more of the criteria listed at right?	☐	☐
Is condition permanent?	☐	☐
Is condition temporary?	☐	☐
If yes, how long? ________Months	☐	☐
Is an attendant required? (If sometimes, choose 'yes')	☐	☐

I certify that I have examined the patient listed above; That I am legally licensed under the laws of the State of Wyoming to practice medicine; and completed this form to the best of my ability.

____
Signature

____
Date

ELIGIBILITY CRITERIA

Non-Ambulatory Disabilities

☐ Impairment which require the individual to use a wheelchair.

Semi-Ambulatory Physical Disabilities

☐ *Restricted mobility*. Disabilities requiring the p**ermanent** use of a walker, cane, crutches, long leg brace or other orthopedic appliances to assist an individual in moving about.

☐ *Cardio-pulmonary disease.* 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.

☐ *Dialysis.* Individual who must use a kidney dialysis machine in order to live.

☐ *Acquired Immune Deficiency Syndrome* (AIDS)

☐ *Other:* Please specify: ______________________________

Hearing Disabilities

☐ *Legally deaf*. Hearing impairment that is bilateral and not correctable with hearing aid.

Visual Disabilities

☐ *Legally blind.* Visual impairment that is bilateral and not correctable with lenses.

☐ *Contraction of visual field.* Persons whose widest diameter of visual filed subtends angular distance of 20 degrees or less than 10 degrees from point of fixation; or whose visual field of efficiency is 20 degrees or less.

Mental Disabilities Complete Parts 1 & II

Part 1

☐ *Developmental disabilities.* Persons with a disability due to mental retardation, autism, or other related condition that originated before age 18.

☐ *Adult cognitive impairment.* Persons whom by reason of traumatic brain injury or illness occurring after the age of 18.

☐ *Epilepsy.* Grand mal or Psychomotor. Persons who are seizure free for a continuous period of six months are disqualified.

☐ *Neurological disabilities.* Neurological and physical impairments not controlled by medication (I.e. cerebral palsy or multiple sclerosis).

☐ *Chronic Mental Illness.* Persons with serious mental health symptoms including schizophrenia, organic brain syndrome and bipolar disorder.

Part II: Applicant must meet one of the following conditions:

☐ Has a mental disorder diagnosis based on criteria in the Diagnostic and Statistical Manual or Mental Disorders (DSM) Specify: ______________________________

☐ Is living in an assisted living home environment.

☐ Is living at home under supervision with agency support services, public guardianship or other appointed guardianship.

☐ Is actively participating in a training or rehabilitation program or therapy established under federal, state or local government agencies.

This form is available large print and in Spanish upon request.