For Senior Citizens and Disabled Persons (this application is available in accessible format) Processing Fee \$3.00 Please Print Application for Regional Reduced Fare Permit

- For Office Use Only -
ID #
PCA
□Temporary
□Permanent
Date

Name			
First	Middle	Last	
AddressStreet	City	State	ZIP
Stieet	·		ΣII
Date of Birth	Phor	ne No Area Code	
Please read the applicar before completing this a	nt section of the <i>Medical Eligibil</i> application.	ity Criteria and Condit	<i>ions</i> brochure
I am applying for a Regional	Reduced Fare Permit on the following	basis. Please check only o	one.
I am 65 years of age or o	lder.		
	igibility and am receiving Social Securi due to disability. (For issuance of a Te		•
I am providing proof of cu	urrent eligibility by the Veteran's Admini	istration as having a disabil	ity of at least 40%.
I am presenting a valid M Temporary Regional Red	ledicare card issued by the Social Secu uced Fare Permit only.	urity Administration. For iss	uance of a
I am providing a valid Re	gional ADA paratransit card, issued by	(Agency	
This ADA paratransit card	d expires	, -	y)
I am providing a valid AD Reduced Fare Permit onl	A paratransit card from outside the reg y.)	jion. (For issuance of a Tem	nporary Regional
I have an obvious physica Eligibility Criteria and Co.	al impairment(s) meeting one or more on the state of the	of the medical criteria listed	I in the <i>Medical</i>
	ng in a vocational career program with ance of a Temporary Regional Reduced	•	idual Educational
	ton Department of Licensing-issued di to identification. (For issuance of a Te		•
(P.A.), Advanced Registe See Health Care Provide	as certified by a Physician, Psychiatrist red Nurse Practitioner (A.R.N.P.) or Au er's Certification form on the reverse act your Health Care Provider for verifi	idiologist, licensed in the Stessible side of this application.	ate of Washington.
Applicant's Signature		Date	
Clallam Transit Community Transit Everett Transit Intercity Transit Jefferson Transit	Kitsap Transit Mason Transit King County Metro Transit King County Ferry District	Pierce Transit Skagit Transit Sound Transit Washington St	ate Ferries (WSF)



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	
AddressStreet	City	State	ZIP
	Oity	DI N	
Date of Birtif		Pnone No Area Cod	e
Applicant's Signature		Date	
This Section To Be	Completed By The Following	Approved Health Ca	re Provider:
Washington State-licensed:	 Physician (M.D.) Audiologist certified by the American Physician's Assistant (P.A.) Advan Signatures of Health Care Provider 	Speech, Language and Heaced Registered Nurse Pract	itioner (A.R.N.P.)
This applicant must mee Conditions brochure.	t at least one of the criteria and condition	ns listed in the <i>Medical Eligii</i>	bility Criteria and
2. The specific Medical Eliq	gibility Criteria number must be noted in	the space provided.	
(a, b, c or d) must be inc rehabilitation program in	is person must be diagnosed by you as be luded along with the name and phone not which this patient is currently a patient. In gram does not, in and of itself, meet elig	umber of the work activity ce Note : An applicant's enrolli	nter, training or
4. An applicant's financial s	situation has no bearing on eligibility.		
I certify that	meets the N	Medical Eligibility Criteria	·
			(Section/Subsection)
, , , , , , , , , , , , , , , , , , , ,	nter name of qualifying program:		
Please check the appropriate Yes No	e Doxes.		
be expected to la	emporary. Specify length of disability: est at least three months, but no longer the Permanent. quires a Personal Care Attendant if yes:	nan one (1) year.	
· · ·	ealth Care Provider – <i>Please Print</i>	, p , p	
Name		Phone No	
Provider or Agency Address			
Washington State License N	0		
Signature		Date	
Original signature – no ph	otocopies or fax accepted.		
	e statements made on this application fo rdance with Washington State Law for fra		will be subject to