Application for Riverside Transit Agency
Disabled Identification Card

Applicant's Name and Address (please print)

Last Name: _____

First Name: _____ **Middle Initial:** _____

Address: _____ **Apt#:** _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: ( ) _____-_____ **Date of Birth:** _____ / _____ / _____

Check the category under which you are applying for a Disabled I.D. Card:
NOTE: Categories 1-5 require you to present your identification card to prove your participation of eligibility in the program checked below.

1. ___ **Medicare Identification Card (white card with red and blue stripes)**
2. ___ **Department of Motor Vehicles (DMV) Disabled Person Placard Identification Card Receipt**
3. ___ **Braille Institute Identification Card**
4. ___ **Disabled Veteran Service - Connected Identification Card**
5. ___ **SSI Award Letter (Social Security Income)**

Please check disability type on the reverse page.

If Categories 1-5 do not apply to you, check either 6 or 7 and follow specific instructions.

6. ___ **Medical Disability – Give this application to your health-care professional to complete based on Eligibility Criteria.**
7. ___ **Special Education – Enrollment in a Special Education Program for students who are enrolled in an elementary, junior/middle or senior high school. Give this application to your Special Education Teacher to complete.**

DEFINITION

Federal Law:
"Handicapped person" means any individual who by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including, but not limited to, any individual confined to a wheelchair, or who is unable without special facilities or special planning or design, to utilize public transportation facilities and services as effectively as a person who is not so affected. A temporary incapacity or disability is an incapacity or disability, which lasts more than 90 days.

I hereby apply for a Riverside Transit Agency Disabled I.D. Card. I authorized my health-care professional or special education teacher to provide medical information. If my application is approved, I agree to abide by the fare policies of the Riverside Transit Agency. I understand that the final determination of my eligibility for reduced fare will be made by the Riverside Transit Agency. I declare, under penalty of perjury under the laws of the State of California, that the responses I have given are true.

Applicant's Signature: _____ **Date:** ____/____/____
(OR LEGAL GUARDIAN IF UNDER 18 YEARS OLD)

After this application has been completed, come to the Janet Goeske Center at 5257 Sierra St, Riverside, on the 2nd Tuesday of each month between 9 a.m. – 12 p.m. or the Simpson Center at 305 E. Devonshire Ave., Hemet, on the 3rd Thursday of each month or the Mary Phillips Senior Center at 41845 Sixth St, Temecula on the fourth Wednesday of each month between the hours of 10 a.m. – 12 p.m. to receive your identification card. There will be a cost of $2.00 for the card. If you have any questions, please call 800-800-7821.

PLEASE CHECK WHICH OF THE REQUIREMENTS BELOW MEET YOUR ELIGIBILITY CRITERIA:

___ Visual impairment such that: (a.) vision in better eye is 20/200 or less after best correction (b.) visual field is contracted of 10' or less from point of fixation or subtends an angle not greater than 20'

___ 50% bilateral hearing loss uncorrected by use of a hearing aid

___ Musculo-sketetal impairment such as muscular dystrophy, osteogenisis imperfecta, or severe rheumatism or arthritis of Therapeutic Grate III, Functional Class III, or Anatomical State III

___ Cardiovascular impairments of Fuction class III or IV or Therapeutic Class C, D, or E

___ Respiratory impairment Class 3 or greater

___ Amputation of or anatomical deformity (due to vascular or neurological deficits, traumatic loss of muscle mass or tendons, or x-ray subluxation) or instability of: both hands; one hand and one foot; one lower extremity at or above torsal region

___ Neurological disorder due to brain dysfunction or damage to the central nervous system, including cerebral palsy resulting aberration of motor functions

___ Paralysis, incoordination or functional motor deficit in any two limbs due to brain, spinal, or peripheral nerve injury

___ Emotional disturbance, including autism, either to the extent that applicant is living in a board and care facility, or at home under supervision

___ Epilepsy (convulsion disorder) involving impairments of consciousness, which occur more frequently than once a month despite prescribed treatment

___ Any other disability you consider will restrict mobility. Please detail below or attach an explanation to application: _____

EXCLUSIONS: Persons are specifically excluded from eligibility whose sole incapacity is:

* Pregnancy
* Obesity
* Acute or chronic alcoholism or drug addiction
* Contagious disease

HEALTH CARE PROFESSIONAL CERTIFICATION:

In my professional judgement this applicant's disability is:

(Check one only) ____ Permanently Disabled ____ Temporarily Disabled For ____ Months

Note: Identification cards will not be issued for less than 3 months or more than 3 years.

Name: (Please Print)_____ Date: ___/___/____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____- _____ California Professional License Number: _____

I understand that failure to certify disabilities in accordance with the above guidelines will result in cancellation of my certification privileges. I hereby declare under penalty of perjury that the information provided is true and correct.

Health Care Professional (Signature): _____

SPECIAL EDUCATION PROGRAM:

Special Education Programs: A student currently enrolled in an elementary, junior/middle or senior high school that is permanently disabled and is receiving services of a Special Education Program.

A Special Education Coordinator may certify a student enrolled in a Special Education Program.

Name of School: _____ Address: _____

Name of Special Education Coordinator: _____ Date:___/___/____

Signature, Special Education Coordinator: _____