Cedar Rapids Transit
Fixed-Route Bus Service
Half Fare Application

APPLICANT’S PERSONAL INFORMATION:

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

Please select one of the following choices:

- I am 65 years of age or older and have provided a copy of my driver’s license; passport; state-issued non-driver’s ID; or Military ID.

- I have provided a copy of my valid Medicare Card issued by the Social Security Administration. (Note: Social Security Award Letters and Medicaid Cards are not accepted as proof for half fares).

- I have provided a copy of a Half Fare Card from another fixed-route transit system.

- I am disabled. (Note: If you select this choice, you must complete the back page of the application).

Applicant’s Signature: ___________________________ Date: ________________

CERTIFICATION AND PROOF OF DISABILITY:

The following agencies are authorized to certify disability eligibility:

- Abbe Center for Community Health
- ARC of East Central Iowa
- Area Payee Service
- Cedar Valley Community Support Services
- Crest Services
- Discovery Living
- Evert Connor Center for Independent Living
- Freedom Foundation
- Goodwill Industries
- Horizons
- Iowa Department for the Blind
- Iowa Vocational Rehabilitation
- Limitless Potential Inc.
- Linn County Community Services
- Linn County MHDD
- Linn County Veteran Affairs
- Options of Linn County
- REM Iowa
- Systems Unlimited
- Total Payee
Cedar Rapids Transit
Half Fare Application
Disability Certification

The applicant, ________________________________, is applying to participate in the Cedar Rapids Transit Half Fare Program, which requires proof of a disability. I am familiar with the applicant's current health status and medical condition and I hereby certify that: (check all that apply):

☐ The applicant has a mental or physical impairment that substantially limits one or more major life activity.

☐ The applicant is unable to use mass transit services as effectively as other individuals because of illness, injury, age, congenital malfunction or other disability.

The condition is expected to last more than 90 days:  ☐ Yes  ☐ No

The condition is expected to last:  ☐ Permanently  ☐ Temporarily*

*Temporary disability is estimated to last until _____________________________________________ (Approximate Date)

Comments Regarding Applicant’s Disability: _____________________________________________

________________________________________________________________________________

Certifying Doctor, Health Care Professional or Provider Agency

I hereby certify that I have personal knowledge of the applicant’s current medical condition and that all statements made in this certification form are true and correct.

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
</tbody>
</table>

(Signature of Doctor, Health Care Professional or Agency Employee) (Date)

CONSENT TO RELEASE INFORMATION: I hereby authorize the release of the requested health and personal information.

(Signature of Applicant) (Date)