



APPLICATION FOR DISABILITY IDENTIFICATION CARD

PLEASE NOTE: All MARTA fixed route buses are accessible to persons with disabilities and equipped with wheelchair lifts. Audible announcements of major bus stops are made on all buses. ADA Priority Service is not available to those individuals who are able to use fixed route bus service.

PLEASE PRINT CLEARLY OR TYPE

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Height: _____ ft _____ inches Weight: _____ Eye Color: _____

Parent/Guardian's Name: _____

Check the category below which qualifies you for a Disability Identification Card.

NOTE: If you check Categories 1, 2 or 3, you must submit a copy of your proof of eligibility with this application. If you check Category 4, you must submit a completed Medical Release and Certification form (on reverse side) with this application. Please submit a photo ID with your application.

1. Social Security Medicare Card or insurance award letter
2. Department of Motor Vehicles Disabled Person Placard Identification Card/Receipt
3. V.A. letter confirming a disability of 50% or greater
4. Medical Disability – Complete Medical Release form (on reverse side) and give to your health care professional to complete.

I declare, under penalty of perjury under the laws of the State of California, that the responses I have given are true.

Signature of Applicant
(or Guardian if applicant is under the age of 18)

Date

Please bring the application with proof of eligibility and photo ID to one of the addresses listed below:

P.O. Box 1501 41939 Fox Farm Rd Big Bear Lake, CA 92315 (909) 878-5200 ph ♦ (909) 878-5207 fax	or	P.O. Box 2409 621 Forest Shade Rd Crestline, CA 92325 (909) 338-1113 ph ♦ (909) 338-6574 fax
---	----	---

MARTA reserves the right to make final determination of eligibility for Disability Identification Cards. This application is for internal use only, and will not be subject to review. It is understood that the identification card is for the purpose of identification for reduced fares on MARTA's transit services; it is not transferrable to other agencies. Should a Disability Identification Card application be denied, the applicant may submit a written appeal within 14 days of the denial date, requesting a review and reconsideration of the application.

Office Use Only -- Do Not Write Below This Line			
Application Received _____			
<input type="checkbox"/> Approved	<input type="checkbox"/> Permanent	Date Issued: _____	Card #: _____
<input type="checkbox"/> Denied	<input type="checkbox"/> Temporary		Expires: _____
Reason: <input type="checkbox"/> Does not meet qualifications	<input type="checkbox"/> Not able to verify	<input type="checkbox"/> Forms incomplete	



MEDICAL RELEASE and PHYSICIAN'S VERIFICATION OF DISABILITY

If you do not have acceptable proof of disability, please complete this form and return it, along with a photo ID, to MARTA. Upon verification of your disability, MARTA will issue a Disabled Identification Card.

Medical Information Release – To Be Completed by Applicant

I hereby authorize:

Physician/Social Worker _____

Address _____

to release to Mountain Area Regional Transit Authority medical or other personal information regarding my disability. The information released will be confined to verification of my status as a patient and the designation of my disability category and will be used solely to determine my eligibility for a Disability Identification Card.

Name of Applicant (please print): _____

Signature of Applicant
(or Guardian if under the age of 18)

Date: _____

REMINDER: Your application for a Disability Identification Card will **NOT** be processed until MARTA has received your completed application (attached) and the certification (completed in full by a qualified health care professional).

Medical Certification – To Be Completed by Health Care Professional ONLY

The MARTA Disability Identification Card allows individuals with disabilities to receive fare discounts as required by State and Federal law. In order to certify that the individual listed above qualifies for the Disability Identification Card and reduced fares, please be sure that you are a licensed physician (M.D./D.O.), licensed physician's assistant or nurse practitioner; licensed chiropractor, optometrist, audiologist, or clinical psychologist; or, licensed social worker.

Eligibility Criteria (check where applicable):

- Non-Ambulatory Requires use of wheelchair
- Semi-Ambulatory Cannot walk unaided or requires mobility device
- Visual Vision is 20/200 or less
- Hearing loss Deafness or hearing loss 70 dba or greater
- Mental Mental impairment limiting ability to care for oneself
- Epilepsy Clinical disorder involving impairment of consciousness; seizures
- Other (please specify) _____

NOTE: *Persons whose primary incapacity is acute chronic alcoholism or drug abuse, obesity, or pregnancy are excluded from eligibility.*

Disability is: Permanent Temporary for _____ months | Attendant Required

Health Care Provider's Name: _____ Field of Practice: _____

Address: _____ CA State License No.: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Fax: () _____

I hereby certify that, in my professional judgment, my patient/client is eligible to receive the MARTA Disability Identification Card and discounted transit fares as a result of a disability (as noted above) that limits his/her ability to use fixed route transit. I am aware that any falsification of a condition or any part of a condition will be reported to the Federal Transportation Administration for prosecution to the full extent of the law.

Signature of Health Care Provider: _____

Date: _____

PLEASE RETURN THE COMPLETED FORM TO APPLICANT OR LEGAL GUARDIAN – DO NOT MAIL TO MARTA