

PEOPLE MOVER Half Fare Program

for People with a Qualifying Disability



This packet contains forms that must be completed in order to enroll in the program.

PROGRAM & ELIGIBILITY INFORMATION

What is it?

The Federal Transit Administration requires transit agencies receiving federal funding for fixed route service to offer a Half Fare Program to Seniors, Medicare Card Holders and people with a qualifying disability. People with qualifying disabilities for this purpose are defined by FTA as persons:

"who by reason of illness, injury, age, congenital malfunction, or other incapacity or temporary or permanent disability (including any individual who is a wheelchair user or has semi-ambulatory capabilities), cannot use effectively, without special facilities, planning, or design, mass transportation service or a mass transportation facility."

Who is eligible?

Having a disability does not necessarily qualify an individual for the Half Fare Program. Income level or employment status are not determining factors. PEOPLE MOVER defines senior citizens as age 60 and over. Excluded conditions to the Half Fare eligibility include: pregnancy, obesity, alcoholism or drug addiction, contagious diseases and disabilities lasting less than 90 days.

How to show proof of eligibility?

Seniors and Youth may show a government issued photo ID to verify age when boarding the bus. Individuals with Medicare cards may show Medicare Card with photo ID to driver as proof of eligibility. All others need to complete the Half Fare Program application process to obtain a PEOPLE MOVER Half Fare ID card. The Half Fare ID Cards are valid for 3 months up to 10 years, length of eligibility depends on information provided by the certifying physician of these forms.

What is the Half Fare ID Card?

The Half Fare ID card is used as proof of eligibility to pay a reduced fare. The card has no cash value and must be shown to the bus operator each time the bus is boarded and the reduced fare is paid.

Is there a cost?

There is a fee for printing/reprinting a Half Fare ID card, please go to our website or call the Rideline to speak with a customer service agent, for the current fares and fees.

Renewals

All half fare cards must be renewed periodically. Individuals certified by completing this application process with approved healthcare providers will be required to obtain a new application packet and have their approved healthcare provider complete the certification forms with their updated eligibility criteria. Renewals should be completed prior to the expiration date on your current Half Fare ID Card, keep in mind processing times when planning for renewals.

THE APPLICATION PROCESS

How do I apply?

To qualify for the Half Fare, it will be necessary for you to complete a half fare application and obtain documentation that proves your eligibility.

The completed application and supporting documentation must be submitted to PEOPLE MOVER directly from the doctor's office.

Fill in your information on page 2, sign for acceptance of policies and authorization for release of information by your treating physician.

Have your physician who is treating you for a qualifying disability complete and sign pages 3 and 5 of this application. The treating physician must be licensed to practice medicine in the State of Alaska.

Leave these forms with your doctor. You should not take these forms with you as your doctor will need to fax or mail this application to our office for review.

Incomplete, illegible or applications that appear to have been altered will be denied and must restart the application process.

Please allow a minimum of 14 business days for processing.

PHYSICIAN INSTRUCTIONS

Complete all questions in all sections on pages 3 and 5 of this application. If a line is provided asking for explanation, it must be completed as well. Please do not leave questions unanswered.

Disability alone does not qualify a person for the Half Fare Program, the disability MUST INHIBIT the applicant's ability to EFFECTIVELY use mass transportation services WITHOUT special facilities, planning, or design.

Income or ability to pay are not factors in determining eligibility.

Use the definitions on page 4 to identify qualifying disabilities and minimum standards to meet that criteria.

RETURN APPLICATION BY FAX TO: (907) 343-4042

PEOPLE MOVER Half Fare Program Application

Last Name												First Name												MI	
Street #				Street Name																Apartment					
City														State				Zip Code							
Date of Birth						Phone #																			
Month		Day		Year		()		-													
Email Address																									

Half Fare Program Eligible Disability

Specify Disability: _____

How does your condition affect your ability to effectively use public transportation?

Do you need special facilities, planning or design to ride fixed-route transit? Yes No
 If yes please explain _____

Do you need the assistance of an attendant to travel? Yes No
 If yes please explain _____

I agree to the following conditions regarding use of a Public Transportation Department (PTD) Smart Card:

- 1.) NOT TRANSFERABLE:** Smart Cards are not transferable and if presented by any person other than to whom it is issued, PTD will confiscate and destroy the card. If a Smart Card has been confiscated due to usage by any unauthorized party, with the Smart Card holder's knowledge, PTD has the right not to issue a replacement card. No exchanges or refunds.
- 2.) PROPERTY OF PTD:** All Smart Cards are the property of PTD and must be presented upon use each time you board a PTD vehicle. This card must be surrendered upon request by a PTD employee.
- 3.) LOST OR STOLEN SMART CARDS:** A replacement fee will be charged for each lost or stolen Smart Card. PTD reserves the right to limit the number of replacement Smart Cards. Without exception, each customer is limited to one (1) Smart Card balance transfer in twelve (12) months.
 A Lost or stolen Smart Card can have the remaining balance transferred to a new Smart Card by:
 - Notifying the Customer Service Office in-person.
 - Presenting the receipt for the fare purchased and uploaded to the lost or stolen Smart Card.
 - Customer Service staff verifies fare receipt against PTD tracking log and documents Smart Card replacement information.
 - Paying the replacement fee for a new Smart Card.
- 4.) DEFACED/DAMAGED SMART CARDS:** Smart Cards that are cracked, have photos or other information that is faded, missing, or scratched off will be considered invalid and subject to confiscation by PTD and replacement fee and remaining fare balances could apply. It is your responsibility to maintain the Smart Card ID in good and usable condition.
- 5.) CODE OF CONDUCT:** The PTD Code of Conduct identified in Anchorage Municipal Code (AMC) 11.070.030 must be followed at all times.
- 6.) BUS FARE:** The Smart Card ID is not a bus fare on its own. It is a reloadable storage media of a digital bus pass but does not by default come loaded with a bus fare. You must purchase and load applicable bus fare as identified in AMC 11.70.060 to use the Smart Card as a bus pass.

I understand that the information collected on this form is for the purpose of determining eligibility for the PEOPLE MOVER Half Fare Program and all information provided will be kept confidential. PEOPLE MOVER maintains the right to verify my eligibility at any time. I affirm that all information given is true and complete. If at anytime my condition of eligibility changes I will notify PEOPLE MOVER and I understand my eligibility can cease until I requalify. I understand that fraud or abuse will result in confiscation of the Smartcard ID and termination of my eligibility of use.

I have read and understand the instruction sheet. I realize that until my PEOPLE MOVER Half Fare Application is approved, I will need to purchase the regular adult fare to use PEOPLE MOVER transit services.

I hereby authorize my HealthCare Provider to release any information necessary to PEOPLE MOVER in determining my eligibility for the PEOPLE MOVER Half Fare Program.

X _____ Date _____

Official Use Only

Reviewed By: _____

Date: _____

Exp. Date: _____

Duration: _____ Months _____ Years

ID number: _____

Comments: _____

Eligible

Incomplete

Ineligible

CRITERIA DEFINITIONS FOR PHYSICIAN'S USE & RETURN INSTRUCTIONS

Ambulatory Disability / Disorder of Gait

Impairment which causes the applicant to be **UNABLE** to move without a mobility/ambulation aid at **ALL TIMES**. The word "UNABLE" is used in its literal sense. The fact that a mobility aid facilitates movement is not sufficient. The type of mobility device will need to be listed on the application, and if at any time applicant is able to move without the device they will no longer qualify with that diagnosis and will need to be re-diagnosed to enter the program again.

Hearing or Visual Disabilities

Legally deaf - a hearing impairment that even with hearing aids, hearing in each ear is NOT restored to one of the following minimum levels:

Average hearing - threshold sensitivity for air conduction of 90 decibels or greater, and for bone conduction to corresponding maximum levels, determined by the simple average of hearing threshold levels at 500, 1000, and 2000 HZ.

Speech discrimination - scores of 40% or less in each ear.

Legally blind - there is central visual acuity of 20/200 or less in both eyes with the use of correcting lenses. Each eye which, accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle of greater than 20 degrees, shall be considered as having central visual acuity of 20/200 or less.

Cognitive Disabilities

Developmental Disabilities - Persons disabled due to intellectual disability, autism or other conditions found to be closely associated with intellectual disability or to require treatment similar to that required by intellectually disabled individuals and:

- a.) The disability originates before such individual attains age 18;
- b.) The condition has continued, or can be expected to continue, indefinitely;
- c.) The condition substantially limits one or more major life activities on an ongoing basis.

Adult Cognition - Persons whom by reason of traumatic brain injury, illness or other accident occurring after age 18 experience ongoing impairment(s) in cognition that substantially limit(s) one or more major life activities, including individuals who meet SSA, SSI, or SSDI eligibility criteria.

Epilepsy - Persons who have suffered any seizure with loss of awareness within the last 6 months. However, persons exhibiting seizure-free control for a continuous period of more than six months duration are not included in the statement of epilepsy defined in this section.

Neurological Disabilities - A person disabled by cerebral palsy, multiple sclerosis, muscular dystrophy, or other neurological and physical impairments not controlled by medication.

Physical Disabilities

Cardiopulmonary Disease/COPD - Serious loss of heart or lung reserves as shown by X-ray, EKG or other tests and in spite of medical treatment, there is possible breathless, pain or fatigue.

Dialysis - Individual who must use a kidney dialysis machine to sustain life.

Loss of extremities - Anatomical deformity or amputation of hand(s) and/or feet, with loss of major function.

Chronic / Serious Mental Illness

Alcoholism, drug addiction and substance abuse are not eligible.

Mental Disabilities - For this application to qualify, an individual must have a mental illness with symptoms chronic in nature who experience a significant limitation in their ability to take part in major life activities, who have a mental disorder diagnosis based on criteria in the *Diagnostic and Statistical Manual IV* of the American Psychiatric Association, **and** who meet one of the following:

Assisted Living Facility/Guardian - Be living in a licensed assisted living facility which must be listed, or provide documentation of a legally appointed guardian.

Social Security Disability - Be receiving Social Security Disability (SSDI) and bring in proof that it is being received.

Actively participating in a program - Applicant must be addressing mental health needs by actively participating in a training, rehabilitation or therapy program established under federal, state, or local government agency. Under this section applicants can only be approved for 6 months at a time and must have a new application completed each time to ensure active participation is being met.

* Applicants with impairments that do not meet the minimum standards outlined in these definitions do not qualify for the PEOPLE MOVER Half Fare Program. Therefore, please mark the box on the front side of this form indicating you can not certify them as meeting the criteria for the Half Fare Program.

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PHYSICIAN'S STATEMENT OF MEDICAL DISABILITY



ONLY TREATING PHYSICIANS/QUALIFIED HEALTH CARE PROFESSIONALS are authorized to fill out **ANY** portion of this application. This form must be fully **completed** to be accepted. Please read "Important" information below.

Eligible Disability Criteria Questions

IMPORTANT - PLEASE READ THOROUGHLY

Not all disabilities qualify an individual to be eligible for the PEOPLE MOVER Half Fare Program. Income or ability to pay are not factors in determining eligibility. The qualifying disability **MUST INHIBIT** the applicant's ability to **EFFECTIVELY** use mass transportation services **WITHOUT** special facilities, planning, or design. PEOPLE MOVER reserves the right not to process any application that is incomplete or if the information provided by the applicant and/or physician is not legible or appears to have been altered.

Disability and Date of Diagnoses: _____

Date of last In-Person appointment: _____

I believe this disability will continue for: _____ months _____ years This condition is permanent in nature, without major medical breakthrough.

Does condition affect the individuals ability to perform activities of daily living (ADL's)?

Yes No

Due to condition, the applicant cannot use public transit without a PCA or person assisting them?

Yes No

(If Yes, please explain)

Does condition affect their ability to ride the bus?

Yes No

(If Yes, please explain) Address need for accessible features, special facilities or planning.

Is the applicant able to:

- * Read information signs?
- * Recognize a destination or landmark?
- * Communicate addresses or destinations?
- * Ask for, understand and follow directions?
- * Use a fixed-route bus independently?
- * Know where to get on/off a fixed-route bus?
- * Stand without major support in a vehicle moving normally?
- * Get on/off a bus with ease, reasonable speed, or without aid?

if you answer "No" to any of these questions, please explain

- | | | |
|------------------------------|-----------------------------|-------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

I AM CURRENTLY TREATING _____ (patient name) for a qualifying disability. I understand that failure to certify applicant disabilities in accordance with the guidelines provided can result in cancellation of my certification privileges. Under the penalty of perjury, I hereby declare that the information provided is true and correct.

Physician's Name _____

Physician's License Type _____

Office Street Address _____

Phone Number w/Area Code Extension _____

Name of Clinic or Practice _____

Physician's License Number _____

City, State, ZIP Code _____

Fax Number w/ Area Code _____

X _____

Authorized Signature (MUST BE AN ORIGINAL)

Copies/Stamped SIGNATURES NOT ACCEPTED

Date of Signature _____

Certification is valid for up to 60 days from date of signature

PLEASE MAKE A COPY OF THIS CERTIFICATION FOR YOUR FILE; PEOPLE MOVER MAY CALL OR FAX FOR VERIFICATION