



# JACKSONVILLE TRANSIT SYSTEM APPLICATION FOR REDUCED-FARE IDENTIFICATION CARD



Updated November, 2017

On behalf of the City of Jacksonville and Jacksonville Transit, Onslow United Transit System, Inc. (OUTS) will only use the information obtained in this certification process for the provision of transportation services. **The information will not be provided to any other person or agency.**

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1. NAME: \_\_\_\_\_

2. ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

3. TELEPHONE #: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

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A passenger may be eligible for a Reduced-Fare Identification Card from Jacksonville Transit, if they meet one of the following qualifying conditions: (Please select one)

- SENIOR CITIZENS (Age 65 & over) and/or MEDICARE CARD HOLDERS** Senior citizens and/or Medicare card holders need to attach a copy of their Medicare Card and a copy of a photo ID.
- PERSONS WITH DISABILITIES** Please complete the attached questionnaire (Pgs. 1 – 4) and have your Licensed or Certified Health Care Provider complete and sign the Professional Certification of Information (Pgs. 5 – 6) enclosed with this application. Both are required in order to determine eligibility for a Reduced-Fare Identification Card for Jacksonville Transit.
- PERSONS AGE 6-18** Please complete this application (Pgs. 1 – 2) and provide a copy of the child’s birth certificate for our files.

Applications can be hand delivered to the Jacksonville Transit One Call Center located at 605 New Bridge Street, Jacksonville, NC 28540, mailed to Onslow United Transit System, Inc. P.O. Box 1548, Jacksonville, NC 28540. It can also be faxed to (910)938-6449.

Applications can take up to ten business days to process. Once an individual is approved, it is necessary that the individual make an appointment to have a Jacksonville Transit Reduced Fare card issued. This card will include a photograph of the qualified individual.

**If this application has been completed by someone other than the person requesting certification, that person must complete the following:**

Name: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



# APPLICANT QUESTIONNAIRE



**A passenger may be eligible for a reduced-fare identification card from Jacksonville Transit, if through illness, age, injury, or congenital malfunction, the passenger is unable to utilize mass transportation facilities and services as effectively as persons who are not so affected. Passengers who qualify for the reduced-fare identification card are those who require special facilities (such as ramps, lifts, or a wheelchair securement system), services (such as audible bus stop announcements), or planning (such as needing an aide to accompany or needing audible crosswalk signals or curb cuts to get to a stop).**

1. As a person with disabilities, please state your disability:

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Is this condition temporary? \_\_\_\_\_ If Yes, expected duration until \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Are there any other effects of your disability of which we need to be aware?

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3. Do you use any of the following aids to mobility? **(Check all that apply)**

Manual or Powered wheelchair \_\_\_\_\_ Walker \_\_\_\_\_ Powered scooter \_\_\_\_\_ Cane \_\_\_\_\_ Crutches \_\_\_\_\_ Personal care attendant \_\_\_\_\_ Guide Dog \_\_\_\_\_

4. Do you require a Personal Care Attendant when you travel using transit?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Sometimes (Please explain) \_\_\_\_\_

5. I hereby certify that the above information given is correct.

Print Name: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_.

**TO THE APPLICANT:**

In order for the Jacksonville Transit System to evaluate your request, you will need to have your physician or other professional to confirm or elaborate on the information you have provided.

I authorize the ADA Coordinator to contact my accredited Health Professional if there is any conflicting information or if further verification is required.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

THE FOLLOWING **PHYSICIAN** \_\_\_\_\_, **CREDITED HEALTH CARE PROFESSIONAL** \_\_\_\_\_ OR **REHABILITATION PROFESSIONAL** \_\_\_\_\_ (**CHECK ONE**) IS FAMILIAR WITH MY DISABILITY AND IS AUTHORIZED TO PROVIDE INFORMATION NECESSARY FOR ONSLOW UNITED TRANSIT SYSTEM, INC. (OUTS) TO COMPLETE ITS EVALUATION OF MY APPLICATION.

**The person identified below will need to complete the next section.**

Physician/Professional's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Applicant's Name (Print or type) \_\_\_\_\_

Applicant's Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**The next section of the application is in reference to the applicant's assessment. This is a critical part of the application and must be completed by a physician or a credentialed health care professional named in the above. Please have the person listed above complete the next section of the application.**



**Jacksonville Transit System  
PROFESSIONAL CERTIFICATION OF INFORMATION**



Applicant's Name: \_\_\_\_\_

Capacity in which you know the applicant: \_\_\_\_\_

Please explain the disability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the condition temporary? No \_\_\_\_\_ Yes \_\_\_\_\_ Expected duration until \_\_\_\_/\_\_\_\_/\_\_\_\_

Does this person use any mobility aids? If so, What? **(Check all that apply)**

Manual or electric wheelchair \_\_\_\_\_ Walker \_\_\_\_\_ Powered scooter \_\_\_\_\_

Cane \_\_\_\_\_ Crutches \_\_\_\_\_ Personal care attendant \_\_\_\_\_ Guide Dog \_\_\_\_\_

B. If the person has a visual impairment:

\_\_\_\_\_ Yes \_\_\_\_\_ No

C. If the person has a cognitive disability; is the person able to:

1. Give addresses and telephone number upon request? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Recognize a destination or landmark? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Deal with unexpected situations or unexpected change in routine? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Ask for, understand and follow directions? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Safely and effectively travel through crowded areas? Yes \_\_\_\_\_ No \_\_\_\_\_

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**CERTIFICATION BY DOCTOR OR MEDICAL AGENCY:** I recommend that this person be deemed eligible for a Reduced-Fare Identification Card, and certify to the best of my knowledge, the above responses are true.

Physician/Professional's Name (please print): \_\_\_\_\_

Specialty: \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_

**Please ensure the application has been fully completed. Incomplete applications will not be processed.**