Rev. 8/19/09

Disability Application for Reduced-Fare Photo ID

The GoPasco Reduced-Fare Photo ID Program allows eligible individuals to ride GoPasco's regular bus routes for a reduced fare by presenting a GoPasco Reduced-Fare Photo ID Card to use or purchase a pass.

Who Qualifies?
Under Federal Regulations 49 CFR, Parts 27 and 37 (or as subsequently amended) – Transportation of Individuals With Disabilities – Disabilities are those permanent or temporary physical or mental impairments that substantially limit one or more of the major life functions of such individual. These may include, but may not be limited to, vision or hearing impairment, mental retardation, motor skills impairment, heart or respiratory ailments.

If you are a Medicare card holder (not Medicaid) you do not need to apply for the Reduced-Fare Photo ID Program. Just present your original Medicare card and a Government-issued photo ID to the bus operator upon boarding to ride for the reduced fare.

How to Apply
All sections of this application must be complete; incomplete applications will be returned unprocessed. After the "Applicant Information and Release" section is completed, the application should be taken to your doctor for certification. Completed applications, which include both pages, must be brought to GoPasco when you have your Reduced-Fare Photo ID card made.

Applicant Information and Release - Please print or type

Name _____

Street Address _____ Unit/Apt # _____

City _____ State _____ Zip Code _____

Telephone Number _____

I authorize the physician completing this application to release information about my disability to the Pasco County Public Transportation (GoPasco) for the purpose of determining my eligibility for the Disabled Reduced-Fare Program. If approved, I will show my photo ID each time I board the bus and upon re-quest, and understand that use of my ID by someone other than me is fraudulent and will result in the revocation of my Reduced-Fare Program privileges.

Signature of Applicant _____ Date _____

Applicant name _____

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Medical Certfication - Please print or type

Physician Name _____ License #/ State _____

Office Address _____ Suite # _____

City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____

What is the applicant's diagnosis/disability? _____

_____

_____

_____

Is the disability permanent?

☐ Yes ☐ No

If no, then for how long? _____

I hereby certify that the medical information provided above is true and correct, and I understand that false or fraudulent statements and certifications are punishable by law under Title 18 USC, Subsection 10001, (1982).

Signature of Physician _____ **Date** _____