Riverside Transit Agency

1825 Third Street | Riverside, CA 92507
(951) 565-5002 | RiversideTransit.com

APPLICATION FOR REDUCED FARE IDENTIFICATION CARD

SECTION I — INFORMATION

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

After this application has been completed, please return it by mail to Riverside Transit Agency, PO Box 59968, Riverside, CA 92517-1968, Attention Reduced Fare ID Cards. A photo ID and proof of disability or age must be provided. Processing fee is $2. You may pay online at RiversideTransit.com or enclose cash or check payable to RTA. You must provide a forward-facing photo, taken with no hats or sunglasses for your card. Please email your photo to adacert@riversidetransit.com with your name, date of birth and the words "Reduced Fare ID." Please allow seven to 10 days for processing.

WHICH ID CARD ARE YOU APPLYING FOR? (CHECK ONE):

- ❑ DISABLED (If you check this box, also provide a photo ID and complete sections II and III)
- ❑ SENIOR (If you check this box, also provide a photo ID and proof that you are at least 60 years old)
- ❑ YOUTH (If you check this box, also provide a school-issued photo ID for grades 1-12)
- ❑ VETERAN (If you check this box, also provide a photo ID and DD Form 214)

I hereby apply for a Reduced Fare ID card and agree to abide by RTA's fare policies. I declare, under penalty of perjury under the laws of the State of California, that the responses I have given on this application are true.

_____ _____

Applicant's Signature (or legal guardian if under 18 years old) *Date*

SECTION II — COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR A DISABLED ID CARD

Which of the following categories can confirm you have a disability? Please check one and provide a copy.

1. _____ Medicare ID Card
2. _____ Department of Motor Vehicles (DMV) Disabled Person Placard Receipt
3. _____ Braille Institute ID Card
4. _____ Disabled Veteran Service Connected ID Card
5. _____ Social Security Disability Income (SSDI) Award Letter

If Categories 1-5 do not apply to you, check either 6 or 7 and follow instructions. Categories 6 and 7 require assistance from a healthcare professional or special education teacher.

6. _____ Medical Disability — Give this application to a licensed healthcare professional to complete Sections III and Section IV.
7. _____ Special Education — Disabled student must be currently enrolled in school and receiving services from a special education program. Give this application to a special education teacher or coordinator to complete Sections III and Section V.

SECTION III – ELIGIBILITY CRITERIA:

Please check which of the below criteria meets your eligibility for a Disabled ID card.

_____ Visual disability (low vision, legally blind, total blindness)
_____ Hearing disability (deaf or at least 50% bilateral hearing loss uncorrected by use of hearing aids)
_____ Musculoskeletal disability (arthritis, osteoarthritis, muscular dystrophy, fibromyalgia, degenerative joint disease or similar condition)
_____ Cardiovascular condition (heart disease, congestive heart failure, peripheral vascular disease)
_____ Respiratory condition (asthma, COPD, emphysema, chronic bronchitis)
_____ Amputation, anatomical deformity (due to neurological deficits, traumatic loss of muscle mass or tendons), or instability of upper or lower extremities
_____ Neurological disorder (cerebral palsy, multiple sclerosis, Parkinson's disease, neuropathy, paralysis, chronic fatigue syndrome)
_____ Paralysis (complete or partial) or functional motor deficit in any limbs due to brain, spinal or peripheral nerve injury
_____ Intellectual or cognitive disability (autism, developmental delay, learning disability, as well as severe mental disorders in which psychoses are prevalent such as schizophrenia)
_____ Seizure disorder or epilepsy
_____ Other disability that restricts mobility (please explain): _____

_____

_____

SECTION IV – LICENSED HEALTHCARE PROFESSIONAL CERTIFICATION

Given my professional judgment, the applicant's disability is (check only one):

_____ Permanent disability
_____ Temporary disability for _____ months

Note: Identification cards will not be issued for less than three months or more than three years.

Healthcare professional name (please print): _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ CA Professional License Number: _____

I hereby declare, under penalty of perjury that the information provided is true and correct.

_____ _____

Licensed Healthcare Professional Signature *Date*

SECTION V – SPECIAL EDUCATION PROGRAM

Student must be currently enrolled in elementary, middle or high school, permanently disabled and is receiving services from a special education program. Verification must be certified by a special education coordinator at the program.

Special education coordinator/teacher name (please print): _____

School name: _____ City: _____

_____ _____

Special Education Coordinator/Teacher Signature *Date*