Application for Riverside Transit Agency Disabled Identification Card

Last Name: _____ First Name: _____
Address: _____ Apt#: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: ( ) _____-_____ Date of Birth: _____ /_____ / _____

Are you eligible for Medi-Cal? ____ Yes ____ No
If yes, what is your Medi-Cal number: _____

Check the category under which you are applying for a Disabled ID Card. Categories 1-5 require you to present your identification card to prove your participation of eligibility in the program checked below.

1. ___ Medicare Identification Card (white card with red and blue stripes)
2. ___ Department of Motor Vehicles (DMV) Disabled Person Placard Receipt
3. ___ Braille Institute Identification Card
4. ___ Disabled Veteran Service - Connected Identification Card
5. ___ SSI Disability Award Letter (Social Security Income)

Please check disability type on the reverse page.

If Categories 1-5 do not apply to you, check either 6 or 7 and follow specific instructions.

6. ___ Medical Disability – Give this application to a licensed healthcare professional to complete based on Eligibility Criteria.
7. ___ Special Education – Enrollment in a Special Education Program for students who are enrolled in an elementary, junior/middle or senior high school. Give this application to your Special Education teacher to complete.

I hereby apply for a Riverside Transit Agency Disabled I.D. Card. I agree to abide by the fare policies of the Riverside Transit Agency. I declare, under penalty of perjury under the laws of the State of California, that the responses I have given are true.

_____ Date: ____/____/____
Applicant's Signature (Or legal guardian if under 18 years old):

After this application has been completed, come to Family Services Association (FSA), 8172 Magnolia Ave., on the second Tuesday of each month between 9 a.m. and 11 a.m. to receive your identification card. A photo ID is required. There will be a cost of $2 for the card. Applications may be processed by mail. For more information or if you have any questions, please call (951) 565-5002 or 511.

APPLICATION CONTINUES >>>>

PLEASE CHECK WHICH OF THE REQUIREMENTS BELOW MEET YOUR ELIGIBILITY CRITERIA:

___ Visual Impairment - low vision, partially sighted, legally blind, total blind
___ Hearing Impairment - total deafness, 50% bilateral hearing loss uncorrected by use of a hearing aid
___ Musculoskeletal Impairments- arthritis, osteoarthritis, muscular dystrophy, fibromyalgia, degenerative joint disease
___ Cardiovascular impairment - heart disease, congestive heart failure, peripheral vascular disease
___ Respiratory impairment - asthma, COPD, emphysema, chronic bronchitis
___ Amputation of or anatomical deformity (due to vascular of neurological deficits, traumatic loss of muscle mass or tendons), or instability of hands, foot, one lower extremity or above torsal region
___ Neurological disorder- cerebral palsy, multiple sclerosis, Parkinson's disease, neuropathy, paralysis, chronic fatigue
___ Paralysis, incoordination or functional motor deficit in any limbs due to brain, spinal or peripheral nerve injury
___ Intellectual disability, including learning disability, autism, and psychosis disorders either to the extent that applicant is living in a board and care facility, or at home under supervision
___ Seizure disorder - Epilepsy involving impairments of consciousness, which occur more than once a month
___ Any other disability you consider will restrict mobility. Please detail below or attach an explanation to application: _____

LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION:
In my professional judgment this applicant's disability is:
(Check one only) ____ Permanently Disabled ____ Temporarily Disabled For ____ Months
Note: Identification cards will not be issued for less than 3 months or more than 3 years.

Name: (Please Print) _____ Date: ____/____/____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone: ( ) _____- _____ California Professional License Number: _____

I understand that failure to certify disabilities in accordance with the above guidelines will result in cancellation of my certification privileges. I hereby declare under penalty of perjury that the information provided is true and correct.
License Health Care Professional (Signature): _____

SPECIAL EDUCATION PROGRAM:
Special Education Programs: A student currently enrolled in an elementary, junior/middle or senior high school that is permanently disabled and is receiving services of a Special Education Program.

A Special Education Coordinator may certify a student enrolled in a Special Education Program.
Name of School: _____ Address: _____
Name of Special Education Coordinator: _____ Date: ___/____/____
Signature, Special Education Coordinator: _____