CITY OF WICHITA/WICHITA TRANSIT
ONE HALF-FARE PROGRAM

Individuals who qualify for Wichita Transit's One-Half Fare Program are entitled to ride regular fixed route buses for one-half the regular adult fare. A special One-Half Fare ID card will be issued to eligible individuals who have qualified for the service by completing the application form. **Wichita Transit's ID card is required and must be shown when boarding the bus in order to receive reduced fare privileges.** Medicare cards are not verification of eligibility.

Who is Eligible?

The One-Half Fare Program is available for those individuals who are 65 years of age or older, for individuals who are Medicare card recipients, or for those who have a physical or mental disability that is verified by a licensed physician.

How Do I Qualify?

1. Fill out the One-Half Fare application.
   Persons 65 years of age or older and/or Medicare cardholders must fill out and sign **Part I** of the application form. Persons with disabilities who are not 65 years of age or older and do not have a Medicare card, must complete and sign **Part I**, and must also have a licensed physician fill out and sign **Part II**.

2. Bring the completed and signed application form and all other supporting documents (including a photo ID, a drivers license, Kansas ID, or birth certificate) to the downtown Transit Center at 214 South Topeka, Wichita, between 8:00 AM and 4:30 PM, Monday through Friday. The application will be processed and your eligibility will be determined. Upon acceptance into the program, you will be issued a One-Half Fare ID card.

Card Replacement

There is no charge for the original ID card. If your card is lost or stolen, please notify Wichita Transit immediately by calling 337-9475. Replacement ID's will be issued at a cost of $2.00 per card. Cards used improperly will be confiscated and privileges will be revoked.

If you have any questions about the One-Half Fare Program, please call 337-9475 between 8:00 AM and 5:00 PM, Monday through Friday.

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WICHITA TRANSIT'S ONE-HALF FARE PROGRAM APPLICATION FORM - PART I

Please list the following information on a separate sheet of paper. Please make sure the documents are signed and dated.

Name: _____
Last First Middle

Address: _____
Street City Zip

Phone Number: _____ _____ SSN: _____

Date of Birth: _____
Month Day Year

I am applying for a Wichita Transit One-Half Fare ID card because:

CHECK ONE

A. I am over 65 years old
Requires a valid drivers license, Kansas ID, or Birth Certificate upon application. _____

B. I have a Medicare Card
You must have your Medicare card and some form of ID upon application. _____
(Kansas Medicaid recipients do not automatically qualify.)

C. I have a legally documented disability
You must have a physician fill out Part II. _____

I certify that the information provided is true and agree to release this information to Wichita Transit for the purpose of obtaining a One-Half Fare card. I understand that the card is for my personal use and will not be transferred to any other person. I grant Wichita Transit permission to verify the information given on Parts I and II of this form.

_____ _____
Signature of Applicant Date

WICHITA TRANSIT'S ONE-HALF FARE PROGRAM APPLICATION FORM - PART II

To Be Completed By A Physician Only

To be eligible for the Wichita Transit One-Half Fare Program, your patient/client must have a physical or mental condition that falls within the medical criteria listed below. If you confirm that the patient/client is physically or developmentally disabled, that person will be eligible for reduced fares on Wichita Transit's public bus services. Persons will not be eligible for reduced fares if their sole capacity is pregnancy, obesity, and acute or chronic condition due to drugs, alcohol, or any contagious disease. All information provided will be held confidential.

A. Physical Disabilities

_____ **1. Restricted Mobility**
Disabilities requiring the use of a cane, crutches, leg braces, walker, or other orthopedic devices used to assist an individual in moving about.

_____ **2. Arthritis**
American Rheumatism Association criteria may be used for the determination of arthritic disability. Therapeutic Grade III, Functional Class III, Anatomical State III, or worse is evidence of arthritic disability.

_____ **3. Loss of Extremities**
Anatomical deformity, amputation of both hands, one hand and one foot, or loss of major function.

_____ **4. Cerebrovascular Accident**
Ongoing debilitating effect which follows an occurrence of a cerebrovascular accident.

_____ **5. Cardio-pulmonary Disease**
Serious loss of heart or lung reserves as shown by X-ray, EKG, or other tests, and in spite of medical treatment, there is breathlessness, pain or fatigue.

_____ **6. Dialysis**
Individual who must use a kidney dialysis machine in order to live.

_____ **7. Acquired Immunity Deficiency Syndrome**
AIDS/HIV positive.

B. Visual Disabilities

_____ **1. Legally Blind**
Visual impairment that is bilateral and not correctable with lenses.

_____ **2. Contraction of Visual Field**
Person whose widest diameter of an angular distance of 20 degrees, or less than 10 degrees from point of fixation, or whose visual field efficiency is 20 degrees or less.

C. Hearing Disabilities

_____ **1. Legally Deaf**
Hearing impairment that is bilateral and not correctable with a hearing aid.

D. Mental Disabilities

_____ **1. Developmentally Disabled**
Mental disability that originates before age 22.

_____ **2. Adult Mental Retardation**

_____ **3. Epilepsy**
Grand Mal or Psychomotor. People who are seizure-free for a continuous period of six months are disqualified.

_____ **4. Autism**
Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli and very inadequate social relationships.

_____ **5. Neurological Disabilities**
Neurological and physical impairments not controlled by medication such as cerebral palsy or multiple sclerosis.

_____ **6. Organic Brain Syndrome/Emotionally Disturbed**
Chronic illness/disturbance that requires boarding or care home, funded work activity or workshop.

Is the disability permanent? Yes ___ No ___

If temporary, please list estimated number of months of temporary disability: _____

I hereby certify that the applicant, _____, is disabled as defined by the preceding criteria and that the information contained on this form is true.

_____ _____
Physician Name Date

_____ _____
Physician Signature Telephone