



## Half Fare Program

### For Persons with Disabilities

Individuals who qualify for Wichita Transit's Half Fare Program are entitled to ride fixed route buses for half the regular adult fare. A special 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.**

#### **Eligibility:**

The Half Fare Program is available for:

- Persons age 65 or older
- Medicare recipients
- Persons with disabilities (verified by a licensed physician)

#### **Steps to apply for a Half Fare ID Card:**

1. **Disabled Individual:** Complete Part I of the Half Fare Program Application Form. Part II will need to be completed by a Licensed Medical Professional.
2. Once completed, have your medical providers office return application by fax to 316-858-7707 or mail to:  
Wichita Transit Center  
214 S. Topeka  
Wichita, KS 67202
3. Your application will be processed and eligibility will be determined. Once approved, you will be contacted by a Wichita Transit staff member. At that time you will be asked to come to the Transit Center in order to have your Half Fare ID card issued. You will be required to provide a photo ID.

#### **Card Replacement**

There is no charge for the initial ID card. If your card is lost or stolen, please notify Wichita Transit immediately by calling 316-265-7221. Replacement ID's will be issued at a cost of \$2.00 per card.

Wichita Transit reserves the right to determine approval of the Half Fare Program. A Half Fare ID Card will not be issued if application fails to provide properly completed application form, failing to provide proper verification or correct payment for replacement cards. Cards used improperly will be confiscated and privileges will be revoked.

If you have any questions about the Half Fare Program, please call 316-265-7221 between 7:00am-5:00pm Monday through Friday.



## Half Fare Program Application Form For Persons with Disabilities

### PART I

Name: \_\_\_\_\_  
Last First M.I

Address: \_\_\_\_\_  
Street City Zip

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I certify that the information provided is true and agree to release this information to Wichita Transit for the purpose of obtaining a Half Fare Program ID 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.

\_\_\_\_\_  
Signature of Applicant Date

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### PART 2

To Be Completed By a Licensed Medical Physician Only

To be eligible for the Wichita Transit Half Fare Program, your patient/client (listed above) 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.

## 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.

## 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.

## Hearing Disabilities

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

## 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.

Is disability permanent?      \_\_\_\_\_ Yes      \_\_\_\_\_ No

If disability is not permanent, estimated duration of temporary disability is \_\_\_\_\_ months.

**Medical/Healthcare Professional Contact Information (Please Print):**

Hospital/Physician's Office/Agency: \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_

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

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

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

*(Must be signed by the physician or recognized professional)*

**IF AVAILABLE, PLEASE STAMP THE BOX BELOW WITH YOUR CONTACT INFORMATION**