APPLICATION FOR DISCOUNT ID

WHO IS ELIGIBLE? A passenger may be eligible for a discount identification card from Fayetteville Area System of Transit (FAST), if through illness, age, injury, or congenital malfunction, the passenger is unable to utilize mass transportation facilities and services as effectively as persons who are not so affected. Passengers who qualify for the discount identification are those who require special facilities (such as ramps, lifts, or a wheelchair securement system), services (such as audible bus stop announcements), or planning (such as needing an aide to accompany or needing audible crosswalk signals or curb cuts to get to a stop).

WHO IS NOT ELIGIBLE? Passengers with disabilities that do not make it substantially more difficult for them to use public transportation when compared to a passenger who does not have a disability are not eligible for the FAST Discount ID card. Examples of disabilities that are included in this category are contagious disease, pregnancy, obesity, and drug or alcohol addiction. Passengers whose disability is corrected with medication, glasses or hearing aids are also not eligible.

To apply for your card, bring this completed form to the FAST Transfer Center, 147 Old Wilmington Road or FAST Administrative Offices, 455 Grove Street, with two forms of identification, one with a picture. **It may take up to 90 days to process completed applications.**

Applicant's Name: _____

Address: _____

City: _____Zip Code: _____

Home Phone: _____Date of Birth: _____

I authorize the health care professional completing this application to release to the City of Fayetteville, Transit Department protected health information related to my disability in order to verify my eligibility for a discounted bus fare. My authorization expires 90 days following the date of signature, below. I understand that my authorization is voluntary and may be revoked at any time by notifying the identified health care professional in writing, that disclosures made pursuant to this authorization may no longer be subject to privacy protections, and that my health care and payment for my health care will not be affected if I refuse to sign this form. I may inspect or copy the protected health information described by this authorization.

Signature of Applicant: _____ Date: _____
(Under 18, Signature of parent or guardian)

TO BE COMPLETED BY A LICENSED OR CERTIFIED HEALTH CARE PROFESSIONAL:

What special facilities does this applicant require to use the bus?
□ bus lift or ramp □ curb-height entrance step □ audio announcements □ visual interior signage

Is an aide needed to assist the applicant when using public transit?

Is this disability permanent, long term (has potential for improvement) or temporary (circle one)?
If temporary, what is the expected duration of the disability? □ 3 months; □ 6 months; □ one year

Please review the Guidelines on the back of this form and list those that apply in the space at the end. Also, please provide specific diagnosis or ICD codes. **Your signature and the applicant's diagnosis are required on the back of this form.**

Last Revised: August 1, 2012

GUIDELINES FOR HEALTH CARE PROFESSIONALS

1. **NON-AMBULATORY**: An individual is unable to walk and requires the use of a wheelchair or other mobility device.
2. **SEMI-AMBULATORY**: An individual is unable to walk without the use of a caliper leg brace, walker or crutches.
3. **UNREMITTING MUSCULOSKELETAL CONDITIONS:** An individual experiences substantial difficulty walking and/or functional limitation of movement.
4. **AMPUTATION:** An individual has an amputation of hands, one arm, one hand and/or one foot, or one or both legs.
5. **STROKE:** An individual has substantial functional motor deficits in any of two extremities, loss of balance and/or cognitive impairments three months post stroke.
6. **PULMONARY OR CARDIAC CONDITIONS:** An individual has a pulmonary or cardiac condition resulting in marked limitation of physical functioning and dyspnea during such activities as climbing steps and/or walking a short distance (200 feet without stopping to rest).
7. **BLIND OR LOW VISION**: An individual whose visual acuity in the better eye, with correction, is 10/200 or less, or who has tunnel vision to 10 degrees or less from a point of fixation so the widest diameter subtends an angle no greater than 20 degrees.
8. **DEAF OR HARD OF HEARING**: (Requires audiologist or otolaryngologist certification) An individual whose hearing loss is 7 dba or greater in the 500, 1000, 2000 KHz ranges in both ears, regardless of the use of hearing aids.
9. **NEUROLOGICAL CONDITIONS OR AUTISM**: An individual has difficulty with coordination, communication, social interaction and/or perception from a brain, spinal or peripheral nerve injury or illness, has functional motor deficits, or suffers manifestations that significantly reduce mobility.
10. **INTRACTABLE EPILEPSY**: In individual has had at least one tonic-clonic seizure within the past six months, despite taking prescribed medication.
11. **DEVELOPMENTAL OR LEARNING DISABILITIES**: An individual has a significant learning, perceptual and/or cognitive disability with a specific diagnosis. Some conditions are excluded from eligibility such as attention deficit disorder (ADD) and dyslexia.
12. **MENTAL ILLNESS**: An individual whose mental illness is chronic, long-term and includes a substantial disorder of thought, perception, orientation, or memory that impairs judgment and behavior. A specific diagnosis is required.
13. **CHRONIC PROGRESSIVE DEBILITATING CONDITIONS**: An individual who experiences debilitating diseases, autoimmune deficiencies, or progressive and uncontrollable malignancies, any of which are characterized by fatigue, weakness, pain and/or changes in mental status that impair mobility.

Name and address of Health Care Professional:

Physician's Speciality: _____

Guideline Numbers(s): _____

Diagnosis or ICD Code(s): _____

Signature of Health Care Professional: _____ Date: _____

FAST Use Only: Card # ID Presented: Exp. Date:

Last Revised: August 1, 2012