**APPLICATION**

HALF-FARE IDENTIFICATION CARDS FOR ELDERLY AND DISABLED PERSONS

SIDE 1 TO BE COMPLETED BY ALL APPLICANTS

Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST 4 DIGITS Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AM APPLYING FOR A GLTC HALF-FARE IDENTIFICATION CARD BECAUSE: **(CHECK ONE)**

\_\_\_\_\_\_\_\_\_\_ I am **65 years old** of age or older, (Please bring this form with Side 1 completed, along with positive proof of age (e.g. driver’s license, birth certificate), to the GLTC Administrative Office.

\_\_\_\_\_\_\_\_\_ I have a ***Medicare Card*** (Please bring this form with Side 1 completed, along with proof of documentation to the Transfer Station.)

\_\_\_\_\_\_\_\_\_ I have a disability that makes me unable to use bus service as effectively as those persons who are not similarly disabled. (If you are applying for a Half-fare ID card under this category, you must have Side 2 of this Application completed and signed by a physician of a representative of an authorized agency.)

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE BRING THIS COMPLETED FORM TO: **Greater Lynchburg Transit Company**

 **Transfer Station**

 **800 Kemper St.**

 **Lynchburg VA 24501**

\*\* You must present this form in person so that your picture can be taken for an Identification Card. A processing fee of **$2.00** will be charged at time of initial issuance or replacement. \*\*

FOR OFFICE USE ONLY

\_\_\_\_\_Approved \_\_\_\_\_Not Approved

By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Side 2 – TO BE COMPLETED FOR APPLICATION WHO HAVE A DISABILITY BY A PHYSICIAN OR AGENCY

I CERTIFY THAT THE INDIVIDUAL IDENTIFIED ON THE FRONT OF THIS APPLICATION QUALIFIES FOR A GLTC REDUCED FARE IDENTIFICATION CARD SERVICES: (Please check as many reasons as applicable).

\_\_\_\_\_ (1) The person cannot board or leave a transit bus with reasonable speed and/or without aid from another person.

\_\_\_\_\_ (2) The person cannot stand without major support in a moving vehicle under normal acceleration and deceleration.

\_\_\_\_\_ (3) The person has uncorrectable vision impairment which makes difficult or impossible to read bus information or bus stop signs.

\_\_\_\_\_ (4) The person has uncorrectable hearing impairment which make difficult or impossible to hear verbal announcements or bus information through either direct personal or electronic communication.

\_\_\_\_\_ (5) The person needs (for valid medical reasons) the aid of a cane, crutches or other mechanical devices to assist him or her in moving about.

\_\_\_\_\_ (6) Due to physical or mental conditions, the person cannot use the bus without the help of another person or special training.

THE PERSON’S DISABILITY CAN GENERALLY BE DESCRIBED AS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ The Disability is permanent.

\_\_\_\_\_ The Disability is temporary and will last until: \_\_\_\_\_\_\_\_\_\_

Due to the disability indicated above I hereby certify that the applicant named on the other side of this application has a disability which limits their ability to use the services of GLTC, and to the best of my knowledge the above information is true and correct.

Authorized Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician or Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print)

Agency Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF MAILING THIS FORM PLEASE USE: **GLTC, PO BOX 11286, LYNCHBURG VA 24506**