



INSTRUCTIONS ON HOW TO APPLY

For a Reduced Fare Identification Card

To avoid a delay in processing of the identification card, this application must be filled out in its entirety. **PHOTOCOPIED OR FAXED SIGNATURES ARE NOT ACCEPTED.**

I. How to Apply:

1. If you have been issued one of the following identification cards:
 - Medicare Identification Card (*white card with red and blue stripes*)
 - Department of Motor Vehicles (*DMV*) Disabled Person Placard Identification Card
 - Braille Institute Identification Card
 - Disabled Veteran Service-Connected Identification Card
 - Other Transit Agency Disabled Identification Card (*not OCTA*)

Complete **SECTION I** (*Application*), and mail along with a photocopy of the identification card to OCTA for processing.

2. If your eligibility is approved by Orange County Behavioral Health, check number 6. Your application will be submitted to OCTA by Behavioral Health through your Care Coordinator or Case Manager.
 3. If you do not qualify under Number 1 or 2 above, please complete **SECTION I**, including the Medical Information Release section. Give the application to your health care professional for completion. Any of the professionals listed on the top of Page 3 in Section III of the application may certify your eligibility, as indicated, for the Orange County Transportation Authority Reduced Fare Identification Card. Mail the completed application to OCTA at the address located below.
 4. If you are a student in an elementary, junior/middle or senior high school and are currently enrolled full-time in a Special Education Program, you must complete **SECTION I** and have the School Psychologist or Special Education Coordinator of your school complete **SECTION II** (*Certification of Disability*). Mail the completed form to OCTA for processing – OCTA Reduced Fare Identification, PO BOX 14184, Orange, CA 92863-1584.
- II. After your application is reviewed and all information is verified, and if your application is approved, you will receive an Eligibility Approval Form from OCTA which includes instructions on how to obtain your photograph and identification card. There is a \$4.00 fee which must be paid at the time your photo is taken.
- III. If your application is denied, you will receive written notification from OCTA that will include a statement as to the reason(s) for the denial. You may appeal OCTA's denial of your eligibility by submitting a written appeal to OCTA within 14 days of the date of the denial notice from OCTA. Your appeal should explain the reason(s) for your request for a review and reconsideration of your eligibility.

If you have any questions regarding this application, please call (714) 560-5596 - Monday through Friday 8:00 a.m. to 2:00 p.m.

Mail to: OCTA RFID / PO Box 14184 / Orange / California 92863-1584



REDUCED FARE IDENTIFICATION CARD APPLICATION

For Persons with Disabilities Riding the Fixed-Route Bus System

OCTA USE ONLY			
ID No:	Code:	Exp Date:	Init:

SECTION I – APPLICANT INFORMATION
Please print or type in BLACK ink. (Photocopied signatures are not accepted.)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: () _____ – _____ Date of Birth: _____ / _____ / _____
Month Day Year

Check the category under which you are applying for a Reduced Fare Identification Card:

NOTE: Categories 1-5 require you to send a photocopy of the identification card to prove your participation or 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 Identification Card/Receipt Copy
3. Braille Institute Identification Card
4. Disabled Veteran Service-Connected Identification Card
5. Other Transit Agency Disabled or Handicapped Person Identification Card (*other than OCTA*)
6. Eligibility approved by the County of Orange Behavioral Health Program. (*If applicant checks this category and County does not include applicant on approved list, application will be returned to the County.*)
7. Medical Disability. Complete Section I, including the Medical Information Release. Give this application to your health care professional. Have the professional complete SECTION II based on Eligibility Criteria listed in Section III.
8. **FULL-TIME** enrollment in a Special Education program for students who have a disability listed under the Eligibility Criteria and are enrolled in an elementary, junior/middle or senior high school. (***Part-time training or tutoring does not qualify.***)
Please provide name of school and grade level you are enrolled in:

School: _____ Grade: _____

Number of hours per week enrolled in special education: _____

Give this application to your school's Psychologist or Special Education Coordinator to have SECTION II completed.

I declare, under penalty of perjury under the laws of the State of California, that the responses I have given are true.

Applicant's Signature: _____ Date: _____

The Orange County Transportation Authority reserves the right to make final determination of eligibility for reduced fare identification cards. This application is for internal use only and will not be subject to public review. It is understood that the issuance of the reduced fare identification card is for the purpose of identification on transit services; it is not transferable. Should an application for the reduced fare identification card be denied, the applicant may submit a written appeal within 14 days of denial letter date, requesting a review and reconsideration of the application.

Mail to: OCTA RFID / PO Box 14184 / Orange / CA 92863-1584 / (714) 560-5596 Mon-Fri 8:00 a.m. to 2:00 p.m.

MEDICAL INFORMATION RELEASE

- In connection with my application for a Reduced Fare Identification Card with the Orange County Transportation Authority, I hereby authorize Dr. _____ to release to the Orange County Transportation Authority, medical or other pertinent information regarding my disability. The information released will be confined to verification of my status as a patient and the designation of my disability category. The information released will be used solely to determine my eligibility for the Reduced Fare Identification Card.
- I realize that I have the right to receive a copy of this authorization.
- I understand that I may revoke this authorization at any time.
- Unless earlier revoked, this form will permit the health care professional who is certifying my disability to release the information described until 60 days after the date appearing below.

Name of Applicant (please print): _____

Signature: _____ Date: _____

SECTION II – CERTIFICATION OF DISABILITY

This section must be completed by a California Licensed Health Care Professional.
(Photocopied and stamp signatures are not accepted.)

To certify a disabled or handicapped person for the OCTA Reduced Fare Identification Card you must:

- Agree to certify as eligible only those individuals who meet the criteria included in this application.
- Agree, upon request, to provide verification of the information on this application.
- Possess the proper professional degree and be licensed in California.
- Agree to **not certify** a person whose disability is solely related to alcohol or substance abuse.

CERTIFICATION:

1. I hereby certify that the applicant's disability or handicap meets the criteria listed in Section III.

Required	
----------	--

(Please choose a classification number from 1 thru 16 from Section III, Eligibility Criteria.)

2. In my professional judgment this applicant's disability is expected to continue for:

Required	
----------	--

(Note: Identification cards will not be issued for less than 3 months or more than 4 years.)

Name (print name of person signing): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: () _____ - _____ FAX Number: () _____ - _____

California Professional License No: _____ Office Manager: _____

Executed this: _____ day of _____ 20 _____
Day Month Year

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.

Health Care Professional (Signature): _____

OR

Special Education Coordinator (Signature): _____

SCHOOL PSYCHOLOGISTS OR SPECIAL EDUCATION COORDINATORS

Full-time Special Education Students: Student applicant must have a medical disability listed under the Eligibility Criteria and be enrolled full-time in special education. *(Applicants receiving part-time training or tutoring do not qualify.)*

Please do not submit applications for special education students who do not qualify under the medical disability category. Reduced Fare ID cards are not issued for socio-economic purposes.

If application is being certified by School Psychologist or Special Education Coordinator, the following information must also be provided: *(Please PRINT in black ink.)*

Name of School: _____ **School Telephone:** () _____ - _____

School Address: _____ **City:** _____ **Zip:** _____

SECTION III – ELIGIBILITY CRITERIA

– Attention Certifying Professionals –

Your patient **must meet one** of the Eligibility Criteria listed on the following two pages.
Questions regarding eligibility should be directed to (714) 560-5596.

THE FOLLOWING HEALTH CARE PROFESSIONALS MAY CERTIFY A PERSON'S DISABILITY OR HANDICAP

M.D. & D.O: All Classifications	Optometrist: Classification 11	Podiatrist: Classifications 1, 2, 3, 4 & 5	Audiologist: Classification 10
Chiropractors: Classifications 1, 2, 3, 4 & 5	Clinical Psychologist: Classification 14	School Psychologist or Special Education Coordinator: All Classifications	

1. NON-AMBULATORY

Impairments that, regardless of cause, make the use of a wheelchair necessary.

2. MOBILITY DISORDERS

Impairments that require individuals to use a functional limb orthotics or longer leg brace, a walker or crutches to achieve mobility.

3. AMPUTATION

Individuals with amputation of, or anatomical deformity of, or traumatic loss of muscle mass or tendons, or X-ray evidence of bony or fibrous ankylosis at an unfavorable angle, joint subluxation or instability of:

- (a) Both hands;
- (b) One hand and one foot; or
- (c) Amputation of lower extremity at or above the tarsal region.

4. FUNCTION MOTOR DEFICIT

Individuals with paralysis, in coordination, or function motor deficit in any two limbs due to brain, spinal, or peripheral nerve injury, including paraplegia, quadriplegia, and hemiplegia.

5. MUSCULO-SKELETAL

Individuals with musculo-skeletal impairments and instability such as muscular dystrophy, multiple sclerosis, osteogenesis imperfecta, severe arthritis as specified below:

American College of Rheumatology criteria to be used for the determination of arthritic disability. Therapeutic Grade III or worse, Functional Class III or worse, and Anatomical Grade III or worse are evidence of arthritic disability.

A diagnosis of Grade III arthritis entails corroborative testing confirming that one or more of the following exists:

- (a) Positive serologic test for rheumatoid factor;
- (b) Antinuclear antibodies;
- (c) Elevated sedimentation rate; or
- (d) Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule.

Certifying professional must provide information as to what test(s) were conducted to arrive at the diagnosis of Grade III arthritis.

6. CONVULSION DISORDER

Individuals who have epilepsy, convulsions, or seizures involving impairment of consciousness which occurs more frequently than once a month despite prescribed treatment.

7. PULMONARY

Individuals with a respiratory impairment, Class 3 or greater, as defined by The Journal of the American Medical Association Guides to the Evaluation of Permanent Impairment, The Respiratory System, 11/22/76.

8. CARDIAC

Individuals with cardiovascular impairments of functional class III or IV and therapeutic classification Classes C, D, or E as defined by Diseases of the Heart and Blood Vessels-Nomenclature and Criteria for Diagnosis, 6th edition, Boston, Little, Brown and Company by the New York Heart Association.

Functional Classification:

Class III – Individuals with cardiac disease resulting in marked limitation of physical activity. Less than ordinary physical activity causes fatigue, palpitation, dyspnea or original pain.

Class IV – Individuals with cardiac disease resulting in inability to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency or of the original syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Therapeutic Classification:

Class C – Individuals with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts must be discontinued.

Class D – Individuals with cardiac disease whose ordinary physical activity is markedly restricted.

Class E – Individuals with cardiac disease who should be at complete rest in a bed or chair.

9. DIALYSIS

Individuals who must use a kidney dialysis machine to live.

10. HEARING DISABILITIES

Deafness or hearing loss that makes an individual unable to hear warning signals. Persons whose hearing loss is 70 dba or greater in the 500, 1,000 and 2,000 Hz. ranges.

11. SIGHT DISABILITIES

Individuals whose visual acuity in the better eye, after best correction, is 20/200 or less; or those individuals whose visual field is contracted to 10 degrees or less from a point of fixation or subtends to an angle no greater than 20 degrees.

12. INFANTILE AUTISM

Individuals with a syndrome described as consisting of withdrawal, inadequate social relationships, language disturbance and monotonously repetitive motor behavior. Many children with autism may also be seriously impaired in general intellectual functioning.

13. MENTAL RETARDATION

Individuals with mental retardation resulting from an impairment in adaptive behavior, with an IQ two standard deviations or more below the norm, or 72.

14. MENTAL DISORDERS

Individuals with a mental or emotional impairment listed in the Diagnostic and Statistical Manual IV of the American Psychiatric Association. The disability must have a minimum duration of three months.

15. NEUROLOGICAL IMPAIRMENTS

Individuals with a neurological disorder due to brain dysfunction or damage to the central nervous system, including cerebral palsy, resulting in aberration of motor functions; or due to brain dysfunction or damage which impairs cognitive functioning.

16. CHRONIC PROGRESSIVE DEBILITATING DISORDERS

Individuals who experience chronic and progressive debilitating diseases that are characterized by constituting symptoms such as fatigue, weakness, weight loss, pain and changes in mental status that, taken together, interfere in the activities of daily living and significantly impair mobility. Following are examples of such disorders:

- (a) Progressive and uncontrollable malignancies (i.e., terminal malignancies being treated with aggressive radiation or chemotherapy);
- (b) Advanced connective tissue diseases (i.e., advanced stage of disseminated lupus erythematosus, scleroderma, or polyarteritis nodosa); and
- (c) Symptomatic HIV infection (i.e., AIDS or ARC in CDC-defined Clinical Group IV, Subgroups A-E).