

Application for Riverside Transit Agency Disabled Identification Card

Last Name: _____ First Name: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: () _____-_____ Date of Birth: ____/____/____

Are you eligible for Medi-Cal? ___ Yes ___ No

If yes, what is your Medi-Cal number: _____

Check the category under which you are applying for a Disabled ID Card. Categories 1-5 require you to present your identification card to prove your participation of 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 Receipt
3. ___ Braille Institute Identification Card
4. ___ Disabled Veteran Service - Connected Identification Card
5. ___ SSI Disability Award Letter (Social Security Income)

Please check disability type on the reverse page.

If Categories 1-5 do not apply to you, check either 6 or 7 and follow specific instructions.

6. ___ Medical Disability – Give this application to a licensed healthcare professional to complete based on Eligibility Criteria.
7. ___ Special Education – Enrollment in a Special Education Program for students who are enrolled in an elementary, junior/middle or senior high school. Give this application to your Special Education teacher to complete.

I hereby apply for a Riverside Transit Agency Disabled I.D. Card. I agree to abide by the fare policies of the Riverside Transit Agency. I declare, under penalty of perjury under the laws of the State of California, that the responses I have given are true.

_____ Date: ____/____/____

Applicant's Signature (Or legal guardian if under 18 years old):

After this application has been completed, return it to the Riverside Transit Agency. A photo ID is required. There will be a cost of \$2 for the card. Applications may be processed in-person or by mail. For more information or if you have any questions, please call (951) 565-5002.

APPLICATION CONTINUES >>>>

PLEASE CHECK WHICH OF THE REQUIREMENTS BELOW MEET YOUR ELIGIBILITY CRITERIA:

- Visual Impairment - low vision, partially sighted, legally blind, total blind
- Hearing Impairment - total deafness, 50% bilateral hearing loss uncorrected by use of a hearing aid
- Musculoskeletal Impairments- arthritis, osteoarthritis, muscular dystrophy, fibromyalgia, degenerative joint disease
- Cardiovascular impairment - heart disease, congestive heart failure, peripheral vascular disease
- Respiratory impairment - asthma, COPD, emphysema, chronic bronchitis
- Amputation of or anatomical deformity (due to vascular or neurological deficits, traumatic loss of muscle mass or tendons), or instability of hands, foot, one lower extremity or above tarsal region
- Neurological disorder- cerebral palsy, multiple sclerosis, Parkinson's disease, neuropathy, paralysis, chronic fatigue
- Paralysis, incoordination or functional motor deficit in any limbs due to brain, spinal or peripheral nerve injury
- Intellectual disability, including learning disability, autism, and psychosis disorders either to the extent that applicant is living in a board and care facility, or at home under supervision
- Seizure disorder - Epilepsy involving impairments of consciousness, which occur more than once a month
- Any other disability you consider will restrict mobility. Please detail below or attach an explanation to application: _____

LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION:

In my professional judgment this applicant's disability is:

(Check one only) Permanently Disabled Temporarily Disabled For Months

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

Name: (Please Print) _____ Date: ____/____/____
Address: _____ City: _____ State: _____ Zip Code: _____
Telephone: () _____ - _____ California Professional License Number: _____

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.

License Health Care Professional (Signature): _____

SPECIAL EDUCATION PROGRAM:

Special Education Programs: A student currently enrolled in an elementary, junior/middle or senior high school that is permanently disabled and is receiving services of a Special Education Program.

A Special Education Coordinator may certify a student enrolled in a Special Education Program.

Name of School: _____ Address: _____
Name of Special Education Coordinator: _____ Date: ____/____/____
Signature, Special Education Coordinator: _____