

Okaloosa County Transit

REDUCED FARE PROGRAM APPLICATION

OCT has a reduced fare program for people with disabilities. Upon presentation of the OCT Reduced Fare Identification Card, people with disabilities are entitled to ride WAVE buses for a reduced fare. The reduced fare is offered during all hours of operation.

Please Print or Type

Name: _____ Date of Birth: _____

Address: _____ Apt # _____

City, State, Zip Code: _____

Telephone: _____ Social Security Number: _____

Definition of a Person with a Disability: A person with a disability is an individual who, by reason of illness, injury, congenital abnormality, or other permanent or temporary incapacity, is unable, without special facilities or planning or design, to use mass transportation facilities and services as effectively as persons who are not so affected. Physical and/or mental disabilities have no age requirement as long as all other criteria are met.

In order to be eligible to ride the bus at the reduced fare for individuals with disabilities, the attached form **must be completed by your Licensed Health Care Provider**. Ask your provider's office to mail or fax this form along with your application to OCT.

Okaloosa County Transit
600 Transit Way
Ft. Walton Beach, FL 32547
Fax 850-833-3980 Phone 850-833-9168

If you are eligible, your Reduced Fare Identification Card will be processed and mailed to you free of charge. You must show the bus driver your card each time you ride the bus. The card is valid for 3 years from the date issued. Replacement cards cost \$5.00 each.

Request for Healthcare Professional Verification

(To be completed by Licensed Healthcare Professional)

Please complete and sign the form below to provide information regarding applicant's disability and its impact upon his/her ability to utilize our transit services. The information you provide will assist Okaloosa County Transit in determining the applicant's eligibility for reduced fare.

Thank you for your cooperation in this matter.

I certify that _____ who currently resides at _____ has been/is my patient and

has a condition that is disabling due to the following criteria(s):

1. Non-Ambulatory Disabilities: Impairments that, regardless of cause or manifestation, for all practical purpose confine individuals to wheelchairs.
Specify Specific Disability

2. Semi-Ambulatory Disabilities: Impairments that cause individuals to walk with difficulty or insecurity. Individuals using braces or crutches, amputees, and those with arthritic, neuromuscular, pulmonary, or cardiac disorders may be semi-ambulatory.
Specify Specific Disability

3. Sight Disabilities: Total blindness or impairment affecting sight to the extent that the individual functioning in public areas is insecure or exposed to danger.
Specify Specific Disability

4. Hearing Disabilities: Total deafness or uncorrectable hearing deficits that might make an individual insecure in public areas because he/she is unable to communicate or hear warning signals.

Specify Specific Disability

5. Neurological Disorders:: Disorders which significantly interfere with coordination, strength, or endurance (cerebral palsy, multiple sclerosis, epilepsy, paralysis).

Specify Specific Disability

6. Mental Disorder: Applicant is unable to perform routine repetitive tasks or has physical or other mental impairment resulting in restriction of function and cannot become licensed to operate a vehicle.

Specify Specific Disability

7. Brain Damage: Diagnosis by a psychiatrist, neurologist, or clinical psychologist establishing that the applicant has organic brain syndrome.

Specify Specific Disability

8. Other:

Specify Specific Disability

Healthcare Professional Name: _____

Office Street Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____ Professional License No.: _____

Signature: _____ Date: _____