Metro Half–Fare Program Application

Eligibility Criteria, Documentation Requirements, Procedures and Application

Metro's Half-Fare Photo Identification Card provides eligible persons the opportunity to ride fixed route and express service at Half-Fare. (Not valid on MOBY which requires ADA certification.) Half-Fares are valid everyday during all hours of bus service operated in Omaha, Bellevue, LaVista, Papillion, NE and Council Bluffs, IA.

The Metro Photo Identification Card must be shown to the bus operator when an individual boards a bus and prior to depositing the cash fare or inserting a Half-Fare ride ticket or Half-Fare card.

The Half-Fare is 60¢. Transfers are 25¢.

A. Eligibility Criteria and Procedure:

1. Senior Citizen - Ages 65 or older

- Must Complete Part One of the Application
- Bring Photo I.D.
- Show valid age documentation (i.e. Driver license, Birth Certificate).

Age 62-64

- Must Complete Part A of the Application
- Bring Photo I.D.
- Social Security Award letter for confirmation; ***or***
- Proof of pension, e.g., Civil Service, railroad, military, etc

2. Medicare Card Holder

- Must Complete Part A of the Application
- Bring Photo I.D.
- Medicare card

3. Disabled Individual

- Must complete and bring Application Parts A and B
- Bring Photo I.D.

Disabled Veteran

- Bring Photo I.D.
- Documentation of VA service- related disability rating of 100%

Part B - Health Care Professional Verification not required for Senior Citizens, Medicare Card Holders and 100% Disabled Veterans

B. Cost for Photo Identification Card

$2.50 for first card
$3.00 for first replacement card
$5.00 for additional replacement cards.

Please bring completed application and documentation to Metro, 2222 Cuming Street, Omaha, NE 68102; Monday – Friday between 8:30 AM and 4:00 PM.

HALF – FARE APPLICATION

Metro Transit ■ 2222 Cuming Street, Omaha, NE 68102 ■ Fax 402.342.0949 ■ TDD 402.342.0949

Part One – Application Information and Release

Mr. Mrs. Ms. _____
Circle One PRINT: Last First Middle

Address _____
PRINT: Number Street City State Zip

Birth Date _____/____/_____ Email _____ Fax _____
Month / Date / Year Print Area Code Number

Telephone: Residence _____; Cell _____; Care Taker _____
Area Code Number Area Code Number Area Code Number

I authorize the health care professional completing this application to release to Metro information about my disability.

_____/_____/_____
Original Signature of Applicant (under 18, signature of parent or guardian) Month / Date / Year

Part Two – Health Care Professional Certificate

INSTRUCTIONS: ✓ as many Criteria as are applicable; sign/date on Page 2 of application.

ELIGIBILITY CRITERIA

_____ Impairments which require the individual to use a wheelchair.

_____ Restricted mobility: Disabilities requiring the permanent use of a walker, crutches, leg / foot braces or other mobility aid devices. Or has one or more missing limbs or critical part thereof use of prosthetic devices.

_____ Cardio – pulmonary disease: Cardiovascular or respiratory condition which significantly interferes with coordination, endurance, or strength. (Eligibility criteria for respiratory is Class III or above.)

_____ Dialysis Treatment – must use kidney machine.

_____ is legally blind; a person whose vision in the better eye after best correction is 20/200 or less; and, a person whose visual field is contracted (commonly known as tunnel vision).

_____ has a severe hearing impairment. Deafness or hearing incapacity that may make an individual insecure in public areas because the individual is unable to communicate or hear warning signals including only those persons whose hearing loss is 90 dba or greater in the 500, 1,000, 2,000 Hz ranges.

_____ has a neurological condition which significantly interferes with coordination, strength, of endurance such as polio, cerebral palsy, multiple sclerosis or paralysis.

_____ has a muscular-skeletal condition which significantly impairs motor skills, such as muscular dystrophy, severe rheumatism or severe arthritis affection two or more limbs. American Rheumatism Association criteria may be used as a guideline for the determination of arthritic handicap. Therapeutic Grade III or worse and Functional Class III or worse and Anatomical State III or worse are evidence of arthritic handicap.

_____ Intellectual Disability: Persons with sub-average general intellectual functioning which originates during the developmental period ad is associated with impairment in adaptive behavior (a general guideline is an IQ more than two standard deviations below the norm).

_____ Adult Cognitive Impairment: Persons whom by reasons of traumatic brain injury or illness suffer mental limitation.

_____ Emotionally Disturbed - To the extent of total disability and 1) living in a board and care home receiving State, county or federal financial assistance and participating in a state, county or federally funded work activity center/workshop; or 2) living at home under supervision and may or may not receive state, county or federal funded state, county or federal work activity center/workshop - *A 12 month certification.*

_____ Epilepsy: clinical disorder involving impairment of consciousness, characterized by major motor seizures (grand mal or psychomotor) substantiated by EEG, occurring more frequently than 1 a month in spite of prescribed treatment with a) Diurnal episodes, or b) Nocturnal episodes showing residuals interfering with day time activities - *A 12 month certification.*

_____Temporary disability: at least 3 months, but no more than 12 months projected to last until _____/____/____.
Month / Date / Year

_____ A student classified as handicapped under guidelines established by the Nebraska Department of Education. For work experience program, this I.D. expires at the end of the school term.

COMMENTS_____

_____

Check ✓ One:	
[ ] licensed physician	**[ ] certified psychologist**
[ ] licensed physical therapist	**[ ] certified rehabilitation**
[ ] licensed occupational therapist	**[ ] speech pathologist**
[ ] licensed social worker	**[ ] vision specialist**
[ ] nurse (LPN or RN)	**[ ] orientation/ mobility specialist**
[ ] certified psychologist	**[ ] audiologist/ hearing specialist**
[ ] psychiatrist, psychologist or	**[ ] deaf/hard of hearing specialist**
[ ] mental health counselor	**[ ] ophthalmologist**

I hereby certify due to checked Criteria, the above named applicant is unable to utilize mass transit facilitates and services as effectively as persons who are not so affected, and to the best of my knowledge the above is true and correct.

Name of Health Care Professional_____

Institution/ Facility/ Agency Name_____

License Number/ State Issued _____

Address _____
Number Street City State Zip

Telephone _____ Fax _____ Email _____

Health Care Professional's Signature_____