

Hi tran REDUCED FARE APPLICATION INFORMATION

1. THIS CERTIFICATION FORM MUST BE FILLED OUT ENTIRELY AND CORRECTLY. ALL INCOMPLETE APPLICATIONS WILL BE RETURNED. PICTURES ARE REQUIRED TO BE PLACED ON ALL ID'S ISSUED AND THIS CAN BE DONE AT THE Hi tran OFFICE BETWEEN 8 a.m.-4:30 p.m. MONDAY-FRIDAY. IF A PERSON HAS A MEDICARE CARD, OR ID THAT PROVES THEY ARE 60 OR OLDER, OR AN ID CARD ISSUED FROM WINSTON OR GREENSBORO, THEY AREN'T REQUIRED TO GET A Hi tran CARD. THERE IS NO REDUCED FARE GIVEN AUTOMATICALLY FOR MEDICAID.
2. PEOPLE CAN BE CERTIFIED BASED ON THEIR AGE (SEE # 1) OR BASED ON DISABILITY (SEE #2)
3. IF A PERSON IS QUALIFYING BASED ON AGE (60+) HE/SHE NEED TO NEEDS A **COPY** OF SOME TYPE OF DOCUMENTAION THAT HAS THEIR NAME & BIRTHDATE ON IT & RETURN IT WITH THE SIGNED APPLICATION.
4. IF A PERSON IS QUALIFYING BECAUSE OF A DISABILITY (IES), A HEALTH CARE PROFESSIONAL OR AGENCY NEEDS TO PUT THE SPECIFIC DISABILITY IN LAYMAN TERMS IN THE REQUIRED SECTION, AND THEN SIGN THE FORM AS WELL AS THE PERSON APPLYING.
5. APPLICATIONS WILL BE ACCEPTED BY MAIL, BUT IF APPROVED, THE CARD ISSUED WILL BE TEMPORARY (60 DAYS) UNTIL THE INDIVIDUAL COMES TO THE Hi tran OFFICE TO HAVE THEIR PICTURE TAKEN & PLACED ON THE CARD.



REDUCED BUS FARE APPLICATION

HIGH POINT TRANSIT SYSTEM
716 W KIVETT DR, HIGH POINT, NC 27262
PH: 889-7433, FAX 883-3425 OR TDD#883-8517

NAME _____ ADDRESS _____
CITY, STATE, ZIP CODE _____ PHONE _____ BIRTHDATE _____
MEDICARE CARD # _____

I. SENIOR CITIZEN (AGE 60 & OVER): THE SIGNATURE OF A DOCTOR OR AGENCY WILL NOT BE NEEDED IF THE PERSON REQUESTING THE CARD WILL **PROVIDE A COPY OF ANY DOCUMENT THAT VERIFIES HIS/HER BIRTHDATE.**

STOP HERE AND SIGN ON LINE IV. ATTACH COPY OF DOCUMENT.

II. HANDICAPPED: HANDICAP OR MOBILITY LIMITATIONS DUE SOLELY TO PREGNANCY, OBESITY, ACTIVE ALCOHOLIC OR DRUG-RELATED PROBLEMS ARE NOT CONSIDERED TO BE ELIGIBLE HANDICAPS FOR PURPOSES OF THIS PROGRAM. **PLEASE LIST SPECIFIC DISABILITY IN LAYMAN TERMS ON LINE BELOW:**

I HAVE THE FOLLOWING DISABILITY(IES) _____
AND THIS SIGNIFICANTLY AFFECTS MY ABILITY TO PERFORM THE FOLLOWING FUNCTIONS
(Check all that apply):
____ getting on and off the bus ____ standing in a moving bus
____ reading information signs ____ hearing request made by driver
____ other (please specify) _____

III. CERTIFICATION BY DOCTOR OR AGENCY: I RECOMMEND THAT THIS PERSON BE DEEMED ELIGIBLE FOR A REDUCED FARE CARD, AND CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE STATEMENTS ARE TRUE.

STAMP/PRINT NAME OF DOCTOR/AGENCY SIGNATURE OF DOCTOR/AGENCY DATE

IV. I CERTIFY THAT THE ABOVE INFORMATION THAT MY DOCTOR, AGENCY OR I HAVE PROVIDED IS TRUE AND CORRECT. I UNDERSTAND THAT MY CARD IS NOT TRANSFERABLE, AND WILL ENTITLE ME TO RIDE FOR ONE HALF HI TRAN'S REGULAR FARE. THEREFORE, IF THIS APPLICATION IS APPROVED AND I AM ISSUED A REDUCED FARE CARD, I MUST ABIDE BY THE RULES AND REGULATIONS SET FORTH BY HI TRAN.

SIGNATURE OF PERSON REQUESTING SERVICE _____ DATE _____

FOR HI TRAN USE ONLY

APPROVAL: YES ___ NO ___ CARD NUMBER: _____
ISSUED BY: _____ ISSUE DATE: _____
Accountant, Office Support or General Manager

...last amendment 01/06

THIS PRINTED MATERIAL WILL BE PROVIDED IN AN ALTERNATIVE FORM UPON REQUEST.