



Attachment A Discount Fare Application

Santa Cruz Metro Center Information Booth
920 Pacific Avenue, Suite 21, Santa Cruz, CA 95060
(831) 425-8600

Hours: Mon-Fri 7:00 a.m. – 5:30 p.m.

Application Information (PLEASE PRINT LEGIBLY): ***ONLY ORIGINAL APPLICATIONS WILL BE ACCEPTED.***

Name: _____
Last name First name

Mailing Address: _____
Street City State Zip

Date of Birth: _____

Telephone number: (____) _____ Email address: _____

Note: Fee payable by cash, check, money order or credit card.

Certification of Eligibility section (Check only one box below):

<input type="checkbox"/> Health Care Provider	To qualify under this type of eligibility you must have the Health Care Provider _____
<input type="checkbox"/> CA Disabled ID	To qualify, must present a valid Identification Card Receipt for a CA Disabled Parking Placard.
<input type="checkbox"/> S	
<input type="checkbox"/> Disabled Veteran	Must present VA Certification or Service Connected ID Card to qualify.
<input type="checkbox"/> V	
<input type="checkbox"/> Medicare Card	To qualify present Medicare Card and legal photo ID.

I agree to release the information I am sending to Santa Cruz METRO for the purpose of making this application for a Discount Fare Card. I certify that the information I provide concerning my application is correct. I understand that Santa Cruz METRO reserves the right to require proof of disability in addition to this form. If applying for the Discount Fare Card, I agree to abide by the terms of the program (AR-1028), and photo ID Card. I give my consent for Santa Cruz METRO, or a Santa Cruz METRO designated Administrative Agency, to take and retain a copy of my photo. **Santa Cruz METRO will not accept a photocopy or fax of this form.**

Signature of applicant: _____ Date: _____



Attachment A Discount Fare Application (Cont'd)

Health care provider certification section: This form is used for individuals with permanent or temporary disabilities. This also includes individuals who may need an attendant to ride Santa Cruz METRO service.

Patient/applicant release:
I authorize: _____ to verify my disability if requested to do so by METRO.
(Name of certified/ licensed health care provider*)
Patient/applicant signature: _____ Date: _____

This portion to be completed by Licensed Health Care Provider ONLY! (see below)

Applicant's name: _____
Applicant's date of birth: _____
Health care provider's name: _____
Title: _____
State certification or license #: _____ Telephone number: _____
Email address: _____
Address: _____

I, _____ hereby certify that I have examined the patient listed above and it is my opinion that he/she is disabled due to illness, congenital malfunction or other incapacity that substantially limits one or more major life functions.

His/Her Disability is:

- Permanent
- Temporary (defined as impairment lasting not more than 12 months). Duration is _____ months.

Does the Patient's disability necessitate the use of a Personal Care Attendant when riding on Santa Cruz METRO service?

- Yes No

The **Category number** of the disability is: _____ **(Please select from Section 4.04- Category Descriptions 1-19).*

I certify that the above is correct and that I am legally certified and/or licensed in my state as a Healthcare Provider.

Signature: _____ **Date:** _____

Customer Service Staff may contact you for verification.
ORIGINAL Completed Application may be mailed to:
Santa Cruz METRO Information Booth, 920 Pacific Station, Suite 21, Santa Cruz, CA 95060