APPLICATION INSTRUCTION SHEET - DISABILITY REDUCED FARE PROGRAM*
Side 1 (Applicant Instructions)

***This reduced fare program is not an Americans with Disabilities (ADA) requirement.**

Section 1: Applicant Information (complete application in black or blue ink only)

Line 1a: Print Last Name, First Name, Middle Initial **Line 1b:** Print Address (Street, City, State, Zip Code)
Line 1c: Print Area Code/Phone Number (Write "NONE" if no phone #). **Line 1d:** Print Month, Day, Year.

Section 2: Applicant Eligibility **

Line 2a: For eligibility under this section, do not complete Section 4 of the application and bring required documentation to the Transit Pass Office.

Department of Veteran Affairs (VA) Disability Benefits:	Submit current (within 12 months of date on application) VA letter for a single disability rated at 40% or more. Copies & digital files not accepted.
Social Security Disability Insurance Benefits (SSDI):	Submit current (within 12 months of date on application) letter for receipt of SSDI. Copies & digital files not accepted.
Disability Parking Permit:	Submit DCAB's original valid Permit ID card.
Amputee:	No documentation, in-person visual confirmation.

Line 2b: Applicant's Health Care Professional (HCP) completes, signs, and dates Section 4.

- For the purposes of this disability reduced fare program, a Person with a Disability does not follow the ADA definition for an individual with a disability & is not an ADA requirement.
- Having a disability alone does not assure that the Applicant will be eligible for the disability reduced fare.
- Section 4b describes the connection between the diagnosis and functional ability to use public transit.
- A reduced fare HOLO card is issued when the supporting evidence of the disability clearly demonstrates Applicant eligibility.

****** Individuals 65 years or older: Apply for a reduced fare Senior HOLO Card.
** Medicare Cardholders under 65 years: Apply for a reduced fare Medicare HOLO Card.
****** Individuals who receive SSI benefits or meet low income requirements: Apply for the Low Income Reduced Fare HOLO Card (https://www.honolulu.gov/dcs/litfp/ or call 808-768-7065 for details).

Section 3: Applicant Statement and Authorization to Release Medical Information

Read, Sign, and Date.

APPLICATION PROCESS (Use only black or blue ink to complete application)

Submit completed/signed application IN-PERSON at the Transit Pass Office.
Located at Kalihi Transit Ctr, corner of Middle St & Kamehameha Hwy - Phone No: 808-848-5555 (press 5).
Office Hours: Monday to Friday, 7:30 AM to 4:00 PM, closed on City Holidays (be in line by 3:30 PM).

Only unaltered original, completed, and signed applications are accepted for processing.

No copies, faxes, or digital signatures.

Applications will not be processed if incomplete, missing required documentation, ID, payment, or submitted after 30 calendar days of the HCP date in Box 4d.

An official, valid picture identification (ID) is required for proof of identity, birthdate, and *Hawaii resident status, such as driver's license, state ID, passport, permanent resident/resident alien ID, federally recognized Indian tribal ID. **Hawaii residency established by Hawaii State ID or Driver's License.*

Only cash or credit card are accepted for payment.

Eligible Applicants are issued a Disability Reduced Fare HOLO Card with photo. Expiration for Section 2a eligibility is 4 years from issue date & expiration for Section 4 is based on HCP date in Box 4d (Permanent disability is 4 years & Temporary disability is expected duration on Line 4c).

APPLICATION INSTRUCTION SHEET - DISABILITY REDUCED FARE PROGRAM*
Side 2 (Health Care Professional Instructions & Appeal Process)

***This reduced fare program is not an Americans with Disabilities (ADA) requirement.**

Section 4: Supporting Evidence of Disability by a Health Care Professional (HCP)
(complete Application Form using black or blue ink only)

- The Disability Reduced Fare Program is not an ADA requirement and does not follow the ADA definition of an individual with a disability.
- Having a disability alone & completing Section 4 does not assure that the Applicant (Patient) will be eligible for the disability reduced fare program.
- HCP shall be licensed in State of Hawaii and certify disabilities only that the HCP is qualified & licensed to diagnose.
- Acceptable License Types APRN, LCSW, MD, PSY, PT, OT.

Line 4a: Read and Print your Patient's first and last name.

Line 4b: Diagnosis and Description of How the Disability Impacts Applicant's Ability to Use the Public Transit System (do not write code only).

- Specify & describe the diagnosis based on medical evidence to clearly demonstrate how the disability impacts the Patient's functional ability to use public transit without significant difficulty/reliance on the accessibility features in the city's transit system.
- Listing only symptoms (ie: weakness, leg pain) or general category of condition (ie: heart condition, mobility condition) are not acceptable.
- Non-qualifying conditions may include but are not limited to: Financial need (low income reduce fare program available-see Section 2** above); temporary durations less than three (3) months; limited-English; conditions with subjective criteria or symptoms that are difficult to measure.

Line 4c: Indicate if the disability is Permanent or Temporary. For Temporary disabilities, indicate the expected duration in months not to exceed 24 months and not less than 3 months.

Box 4d: Print HCP Name, Address, Phone No., License Type & Number, License Expiration Date.

Use Agency stamp to identify Agency or Print Agency Name if no Agency stamp.

HCP signature to certify Applicant is their patient & information provided is true & correct.

Digital signatures and faxed copies are not accepted.

Date of signature.

Transit Pass Office may conduct follow-up verification of signature.

APPLICANT APPEAL PROCESS

Applicants may appeal determinations that they do not qualify for the Disability Reduced Fare Program by contacting the Department of Transportation Services (DTS) within 30 calendar days of the determination date by calling 808-768-8368 or emailing thebusstop@honolulu.gov to obtain instructions on filing an appeal.

The determination date is located in the "for official use" box on side 1 of the application that was not processed and a copy returned to the Applicant.

APPLICATION FORM - DISABILITY REDUCED FARE PROGRAM*
Side 1 (to be completed by Applicant using black or blue ink only)

***This reduced fare program is not an Americans with Disabilities (ADA) requirement.**

Transit Pass Office located at Kalihi Transit Ctr. (Corner of Middle St. & Kamehameha Hwy.)
TheBus Customer Service (808-848-5555 press 5)

SECTION 1: APPLICANT INFORMATION (see Instruction Sheet – Side 1)

1a. Applicant's Name: _____ _____
LAST FIRST MIDDLE INITIAL

1b. Address: _____ _____
CITY STATE ZIP CODE

1c. Phone Number: ( ) _____ **1d. Birth Date:** _____
MONTH, DAY, YEAR

SECTION 2: APPLICANT ELIGIBILITY – Check only one (1) Box in 2a or 2b

- Applicant is 65 years or older, apply for a Senior Reduced Fare HOLO Card.
- Applicant is a Medicare Cardholder under 65 years old, apply for a Medicare Reduced Fare HOLO Card.
- Applicant receives SSI benefits or meets low income requirements: Apply for the Low Income Reduced Fare HOLO Card (https://www.honolulu.gov/dcs/litfp/ or call 808-768-7065 for details).

Applicant is under 65 years old - Check only one (1) box in 2a or 2b (see instructions for requirements).

2a. ☐ receives Department of Veteran Affairs (VA) or Social Security Disability Insurance (SSDI) benefits.

☐ has a valid State of Hawaii Disability Parking Permit Card issued by DCAB.

☐ is an amputee (leg/foot, arm/hand).

2b. ☐ submits Section 4 completed & signed by a Health Care Professional (HCP).

- eligibility for the reduced fare does not follow ADA definition of an individual with a disability.
- HCP certification does not assure that the Applicant will qualify for the disability reduced fare.

SECTION 3. APPLICANT STATEMENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I acknowledge: **1)** HCP certification of a disability in Section 4 does not automatically qualify me for this reduced fare program, **2)** false information may invalidate my HOLO reduced fare card, **3)** my application will be rejected if incomplete or submitted after 30 calendar days of the HCP date in 4d.

I authorize release of my medical information in Section 4.

_____
Applicant's Signature Date

_____
Parent/Guardian's Signature if Applicant is under 18 Relationship/Authority, if other than the Applicant Date

FOR OFFICIAL USE ONLY - DO NOT WRITE IN THIS BLOCK

☐ Applicant Eligibility Approved. ☐ Resident ☐ Non-Resident Amount paid: $_____

☐ Application Not Processed: Reason: _____

Notes:_____

Processing clerk: _____ Date: _____

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APPLICATION FORM - DISABILITY REDUCED FARE PROGRAM*

Side 2 (to be completed by the Health Care Professional using black or blue ink only)

***This reduced fare program is not an Americans with Disabilities (ADA) requirement.**

SECTION 4: SUPPORTING EVIDENCE OF DISABILITY BY A HEALTH CARE PROFESSIONAL (HCP)
(See Instruction Sheet Side 2)

- For the purpose of this disability reduced fare program, a person with a disability does not follow the ADA definition for a person with a disability and is not an ADA requirement.
- HCP shall be licensed in the State of Hawaii.
- HCP shall certify disabilities only that the HCP is qualified & licensed to diagnose.
- HCP shall certify disabilities based on medical evidence.
- HCP certification of a disability does not assure that the Applicant will qualify for the disability reduced fare program.

4a. I certify that the Applicant (Name)_____

- is my patient,
- is diagnosed with a disability which makes it significantly difficult to perform functions necessary to effectively use the city's transit system,
- is reliant on the accessibility features in the city's transit system - disability impacts functional ability to use public transit service without such accommodations.

4b. Diagnosis & Description of How the Disability Impacts Applicant's Ability to Use the Public Transit System (do not write code only - see Instruction Sheet Side 2).

_____

_____

_____

_____

_____

_____

4c. □ **Permanent or** □ **Temporary: Expected duration of disability:** _____**mos.** (not less than 3 mos. & no more than 24 mos.)

4d. HCP Certification. As an HCP duly licensed in the State of Hawaii, I certify: 1) the Applicant is my Patient, 2) I completed this application with true & correct information. 3) I understand that providing false information are grounds for Licensing sanctions under HRS Chapter 436B.

Name: _____ **Phone No: ( )** _____

License No & Type: _____**Expiration Date:** _____
(Acceptable Types: APRN, LCSW, MD, PSY, PT, OT)

Agency (Stamp): _____

Address: _____
City **State** **Zip Code**

Signature: _____ ***Date:** _____

***Applications are void if submitted after 30 days of this date.**

Only unaltered original, completed, and signed applications are accepted for processing.
No copies, faxes, or digital signatures.