INSTRUCTION SHEET – Person with a Disability HOLO Card Application
说明页——残障人士HOLO卡申请表

为符合残障人士 HOLO 卡减费票价的资格，残障人士的定义为个人因残障/状况，如无特殊设施、规划或设计，则无法有效使用城市公交系统，以致于无法在不承受重大困难的情况下执行必要的某些特定功能以有效使用城市公交系统。

残障人士 HOLO 卡将由Transit Pass Office（公交通票办公室）在确定证明文件/证据清楚地表明申请人就本申请而言符合残障人士资格后发出。

申请人说明（请用英文工整清楚填写，并仅使用黑色或蓝色墨水）

第1部分：申请人信息

1a 行：工整填写全名（姓、名、中间名缩写）

1b 行：工整填写完整地址（街道、城市、州、邮政编码）

1c 行：工整填写区号和电话号码。如无电话号码，则写“NONE”（无）

1d 行：工整填写出生日期（月、日、年）。

第2部分：申请人资格**

2a 行：退伍军人事务部 (VA) 残障福利：提交被评级为 40% 或更高的单一残障的原始信件。
社会保障局残障福利：提交领取社会保障残障保险 (SSDI) 福利的原始信件。
残障人士停车许可证：提交 DCAB 发出的有效许可证身份证原件。
截肢者：无证明文件，面见目视确认。

2b 行：申请人的医疗保健专业人士通过完整填写并签署“第4部分：残障支持证据”以提供现今残障支持证据。

** 年满65 周岁的个人：请申请减费老年人 HOLO 卡。
** 未满65 周岁的联邦医疗保险(Medicare) 持卡人：请申请减费联邦医疗保险(Medicare) HOLO 卡。

第 3 部分：用以披露医疗信息的申请人声明和授权

阅读、签名并写明日期

HEALTH CARE PROFESSIONAL INSTRUCTIONS (use black or blue ink only)
医疗保健专业人士说明

Section 4: Supporting Evidence of Disability by a Health Care Professional

Section 4 shall be completed & signed by a Health Care Professional licensed in the State of Hawaii as defined in HRS §451D-2. Certification of disability shall only be in the field(s) covered by the relevant Medical License. Health Care Professionals defined in HRS §451D-2 and recognized by the Department of Transportation Services includes physicians (HRS §453), naturopathic physicians (HRS §455), advanced practice registered nurses (HRS §457), podiatrists (HRS §463E), and psychologists (HRS §465).

INSTRUCTION SHEET – Person with a Disability HOLO Card Application
说明页——残障人士 HOLO 卡申请表

HEALTH CARE PROFESSIONAL INSTRUCTIONS continued from page 1

Line 4a: Print applicant's name. Lines 4a1 or 4a2: Select the Applicant's qualification category.

Line 4b: Diagnosis and description of disability/condition to certify Line 4a1 or Line 4a2 (do not write code only).

Specify the disability based on medical evidence to clearly demonstrate the Applicant's inability to effectively use the city's transit system without significant difficulty or special facilities, planning, or design.

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; temporary durations less than one month; limited-english proficiency, pregnancy; obesity; contagious diseases; substance/alcohol abuse/addiction; mental health conditions with subjective criteria or symptoms that are difficult to measure, in remission, or with indeterminate diagnosis; attention deficit disorder/attention deficit hyperactivity disorder.

Line 4c: Describe the special facility, planning, or design that the Applicant needs to effectively use the city's transit system due to the disability/condition specified in 4b.

Line 4d: Indicate if the Applicant's disability is Permanent or Temporary. For Temporary disabilities, indicate the expected duration in months not to exceed 24 months and not less than 1 month.

Box 4e: Print Name, Address, Phone No., License No., License Type, License Expiration Date. Use Agency stamp to identify Agency or Print Agency Name if Agency does not have a stamp. Signature of Health Care Professional to certify the Applicant's qualifying disability on this Application and date of signature. Digital signatures and faxed copies are not accepted. Transit Pass Office may conduct follow-up verification of signature.

申请程序

仅使用黑色或蓝色墨水完整填写申请表。

申请人应亲自到Transit Pass Office（公交通票办公室）提交已完整填写/签名的申请表。

地址：Kalihi Transit Center（卡历黑公交中心） —Middle St.（中街）和Kamehameha Hwy（卡美哈美 哈公路）两条街道转角处

办公时间：周一到周五，上午7:30 到下午4:00，城市假日休息

电话号码：808-848-5555 （按4）

仅未更改的原始、完整和经签名的申请才得以接受进行受理。不接受复印件、传真或数字签名。

如果申请不完整，缺少所需证明文件、身份证件、付款，或在 4e 方框中医疗保健专业人士所示日期起30 个公历日后才提交，则申请将不予受理。

需要出示官方有效的带照身份证件 (ID)以证明身份、出生日期和*夏威夷居民身份。可接受的身份证件形式包括驾照、州身份证件、护照、永久居民/外籍居民身份证件、联邦认可的印第安部落身份证件。*证实夏威夷居住身份可通过其他证明文件。

只接受现金或信用卡付款。

在Transit Pass Office（公交通票办公室）确定证明文件表明申请人就本申请而言符合残障人士资格后，带申请人照片的残障人士 HOLO 卡将会发出。

有效期基于 4e 方框中的医疗保健专业人士所示日期。
终身残障：四 (4) 年　　暂时残障：预期期限见4d 行。

APPLICATION for a PERSON WITH A DISABILITY HOLO CARD
残障人士 HOLO 卡申请表

Chinese Simplified

Transit Pass Office（公交通票办公室）—电话：808-848-5555 按 4
位于 Kalihi Transit Center（卡历黑公交中心）—
Middle St.（中街）和 Kamehameha Hwy（卡美哈美哈公路）两条街道转角处

第 1 部分：申请人信息（请用英文工整清楚填写，并仅使用黑色或蓝色墨水）

1a. Applicant's Name: _____
申请人姓名: LAST 姓 FIRST 名 MIDDLE INITIAL 中间名缩写

1b. Address: _____
地址 CITY 市 STATE 州 ZIP CODE 邮政编码

1c. Phone Number: ( )_____ **1d. Birth Date:** _____
电话号码 出生日期 MONTH, DAY, YEAR 月、日、年

第 2 部分：申请人资格—只勾选一（1）个方框

如果申请人年满 65 周岁，请申请老年人 HOLO 卡。
如果申请人为未满65 周岁的的联邦医疗保险(Medicare)持卡人，请申请联邦医疗保险(Medicare)HOLO 卡。

申请人未满 65 周岁且：（只勾选 2a 或 2b 部分中的一 (1) 个方框，并查看说明页第 1 页中的要求）

2a. ☐ 领取退伍军人事务部 (VA) 或社会保障残障保险(SSDI) 福利。
☐ 持有DCAB发出的有效夏威夷州残障人士停车许可证。
☐ 为截肢者（腿/脚，臂/手）。

2b. ☐ 提交第 4 部分中的由医疗保健专业人士提供的支持证据。

第3部分：用以披露医疗信息的申请人声明和授权

由于本人残障/状况，如无特殊设施、规划或设计，本人则无法有效使用城市公交，无法在不承受重大困难的情况下执行必要的某些特定功能以有效使用城市公交。本人确认：1) 提供虚假信息会致使本人的 HOLO 卡失效，2) 如果本人未提交完整申请或在第 4e 部分中医疗保健专业人士所示日期起 30 个公历日后才提交，本人的申请将会被拒，3) 在 Transit Pass Office（公交通票办公室）确定支持证据清楚地表明本人符合资格获得残障人士减费票价时，HOLO 卡会发出。

本人授权披露在本申请表第 4 部分中的关于本人的医疗信息。

_____ _____
Applicant's Signature 申请人签名 Date 日期

_____ _____ _____
Parent/Guardian's Signature if Applicant is under 18 父母/监护人签名（如果申请人未满 18 岁） Relationship/Authority, if other than the Applicant 关系/授权（如非申请人） Date 日期

FOR OFFICIAL USE ONLY - DO NOT WRITE IN THIS BLOCK 办公专用—请勿在此方框中填写

Health Care Professional License No:_____ Type:_____Expiration Date: _____
Health Care Professional Signature Verification: ☐ Sample on File ☐ Follow-up with Agency ☐ Other _____
☐ Application Processed: ☐ Permanent ☐ Temporary: _____months ☐ Resident ☐ Non-Resident
HOLO Card: Expiration Date: _____ HCP Section 4 Date: _____
Amount Paid $_____☐ Card Fee, ☐ Stored Value, ☐ Monthly Pass, ☐ Annual Pass
☐ Application Not Processed: Reason: _____

Signature: _____ Date: _____
(PROGRAM COORDINATOR)

第 4 部分由医疗保健专业人士完整填写(use black or blue ink only)
(Section 4 instructions on pages 1-2 of Application Instruction Sheet)

SECTION 4: SUPPORTING EVIDENCE OF DISABILITY BY A HEALTH CARE PROFESSIONAL

The Department of Transportation Services recognizes Health Care Professionals defined under HRS §451D-2 who are licensed to practice in the State of Hawaii and includes physicians (HRS §453), naturopathic physicians (HRS §455), advanced practice registered nurses (HRS §457), podiatrists (HRS §463E), and psychologists (HRS

§465). Supporting evidence of disability shall be only in the fields covered by the Health Care Professional's State of Hawaii License.

4a. I certify that (Applicant's Name) _____has a disability/condition under <u>one</u> of the following categories and <u>requires special facilities, planning, or design</u> to effectively use the city's transit system without significant difficulty.

☐ **4a1.** The Applicant by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or physical or mental disability, is unable, without special facilities or special planning or design, to utilize the city transit system.

☐ **4a2.** The Applicant has an incapacity or disability that results in the inability to perform one or more of the following functions necessary for the effective use of the city's transit system without significant difficulty:

- ☐ Negotiating a flight of stairs, escalator or ramp;
- ☐ Boarding or alighting from a city transit vehicle;
- ☐ Reading informational signs (vision acuity related), or
- ☐ Walking more than 200 feet.

4b. Diagnosis & Description of Disability (to certify checked box above – do not write code only)

_____

4c. Specify the special facility, planning, or design the Applicant needs to use city transit.

_____

4d. ☐ Permanent or ☐ Temporary: Expected duration of disability: _____months. (maximum 24 months)

4e. <u>Health Care Professional Certification</u>. As a Health Care Professional duly licensed in the State of Hawaii, I understand that falsely certifying the Applicant's disability/condition for the purposes of this application form are grounds for Licensing sanctions under HRS Chapter 436B.

Name: _____ Phone No: ( ) _____

License No: _____License Type:_____License Expiration Date: _____

Agency (Stamp): _____

Address: _____

City State Zip Code

Signature: _____ *Date: _____

***Applications will be rejected 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.