APPLICATION
TheBus PERSON WITH A DISABILITY IDENTIFICATION CARD OR PASS
TheBus Pass Office, Oahu Transit Services, Inc. (OTS)
Kalihi Transit Center
Corner of Middle Street & Kamehameha Highway
Telephone: 848-5555 press 4

SIDE 1: APPLICANT INFORMATION

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

2. Phone Number: ( )_____ **3. Email:** _____

4. Address:_____

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

5. Birth Date: _____ **6. Date of Application:** _____
MONTH, DAY, YEAR DATE OF SUBMISSION

7. APPLICANT'S DECLARATION & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I declare, that the information provided is true and accurate to the best of my knowledge; and I acknowledge that providing false information on this application may invalidate the ID card or pass.

I also authorize my Heath Care Professional (licensed in the State of Hawaii) to release medical information necessary to process this application.

I acknowledge, that the Health Care Professional Certification (HCPC) date is valid for only 30 calendar days and this application will be rejected if submitted after 30 calendar days of the HCPC date.

X_____ _____
APPLICANT'S SIGNATURE Date

X_____ _____
PARENT/GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 Date

Relationship/Authority, if other than the Applicant_____

FOR OFFICIAL USE ONLY - DO NOT WRITE IN THIS BLOCK

Health Care Professional License Verification: License Status: _____ Expiration Date: _____
Health Care Professional Signature Verification: ☐ Sample on File ☐ Agency Faxed Sample ☐ Other _____
☐ Application Processed: ☐ Permanent ☐ Temporary: _____months HCPC Date: _____
☐ ID Card ☐ Pass Expiration Date: _____Amount Paid $_____
☐ Application Not Processed: Reason: _____

Signature: _____ Date: _____
(PROGRAM COORDINATOR)

Revised 9/3/2020

SIDE 2: CERTIFICATION BY LICENSED HEALTH CARE PROFESSIONAL:
A Health Care Professional includes a clinical social worker, occupational therapist, physiatrist, physical therapist, rehabilitation specialist, medical physician, registered nurse, psychologist or similar professional, duly licensed to practice in the State of Hawaii.

8a. I certify that (Applicant's Name) _____qualifies for TheBus Person with Disability Identification Card or Pass under <u>one</u> of the following categories:

- ☐ The Applicant by reason of illness, injury, advanced age, congenital malfunction or other permanent or temporary incapacity or disability, is unable without special facilities or special planning or design to utilize the city bus system as effectively as a person who is not so affected.
- ☐ The Applicant has a physical or mental disability which clearly demonstrates that the person experiencing such disability is unable, without difficulty or assistance, to utilize the city bus system.
- ☐ The Applicant has an incapacity or disability which results in the inability to perform one or more of the following functions necessary for the effective use of the city bus system's facilities without significant difficulty (check all that apply):
    - ☐ Negotiating a flight of stairs, escalator or ramp;
    - ☐ Boarding or alighting from a city transit bus;
    - ☐ Reading informational signs; or
    - ☐ Walking more than 200 feet.

8b. Description of Disability: _____
(to certify checked box above – do not write code only)

8c. ☐Permanent or ☐Temporary (Expected duration of disability: _____months.)

8d. <u>Health Care Professional Certification</u>. As a Health Care Professional duly licensed in the State of Hawaii, I understand that falsely certifying that the Applicant is qualified for the purposes of this application form are grounds for Licensing sanctions under HRS 436B.

Name: _____ Phone No: ( ) _____

Agency (Stamp): _____ License No: _____

Address: _____License Expiration Date: _____

City: _____State: _____ Zip Code: _____

Signature: _____ *Date: _____

***The Expiration Date of TheBus Person with a Disability Identification Card or Pass is based on the Health Care Professional Certification date.**

APPLICATION INSTRUCTION SHEET

TheBus PERSON WITH A DISABILITY IDENTIFICATION CARD OR PASS

SIDE 1: APPLICANT INSTRUCTIONS

1. **Applicant's Name:** Print your name (Last Name, First Name, Middle Initial).
2. **Phone Number:** Print your telephone number. If you do not have a telephone number, write "NONE."
3. **Email is optional.** OTS will use it ONLY to contact you for Disability Bus Pass purposes.
4. **Address:** Print your address.
5. **Birth Date:** Print the month, day, year.
6. **Date of Application:** Input the date that you submit the application in-person (Submit your application within 30 calendar days of the Health Care Professional Certification date).
7. **Declaration and Authorization to Release Medical Information:** Signature to verify the information you provided is correct; authorize your health care professional to complete Side 2 & release medical information (the medical information provided will only be used to determine eligibility for a disability bus identification card or pass); and acknowledge that this application will be rejected if submitted after 30 calendar days of the Health Care Professional Certification date.

SIDE 2: LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION INSTRUCTIONS

8a. Certify Applicant's disability by checking the appropriate category box.

8b. Describe disability to certify the category box checked in 8a (do not write disability codes only).

8c. Indicate if the Applicant's disability is Permanent or Temporary. For Temporary disabilities indicate the expected duration in months.

8d. Print Name, Address, Phone No., License No., and License Expiration Date.
Use Agency stamp to identify Agency or Print Agency name if Agency does not have a stamp.
Signature to certify the Applicant's qualifying disability on this Application & date of signature.

TheBus PERSON WITH A DISABILITY ID CARD or PASS APPLICATION SHALL BE SUBMITTED <u>IN-PERSON</u> BY THE APPLICANT AT TheBus PASS OFFICE.

1. Only original, completed, and signed applications are accepted for processing. No copies. (Incomplete applications will NOT be processed. Complete all lines with true/accurate information)
2. An official, valid picture identification (ID) is required for proof of identity (Acceptable forms of ID include driver's license, state ID, passport, other government agencies ID).
3. Cash, institutional check, or credit card for payment – No personal checks.
4. The Expiration Date is based on the Health Care Professional Certification date.
5. TheBusPass Office is located at the Kalihi Transit Center, corner of Middle St. & Kamehameha Hwy.
   Office Hours: Monday – Friday, 7:30 a.m. – 4:00 p.m. (Closed on City Holidays)
   Phone No. (808) 848-5555 press 4