INSTRUCTION SHEET – Side 1
Disability Reduce Fare Program Application
(use black or blue ink only)

Section 1: Applicant Information

Line 1a: Print your full name (Last Name, First Name, Middle Initial).

Line 1b: Print your complete address (Street, City, State, Zip Code).

Line 1c: Print your area code and telephone number. Write "NONE", if no phone number.

Line 1d: Print your birth date (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 original letter for a single disability rated at 40% or greater.

Social Security Disability Insurance Benefits (SSDI): Submit original letter for receipt of SSDI.

Disability Parking Permit: Submit original valid Permit ID card issued by DCAB.

Amputee: No documentation, in-person visual confirmation.

Line 2b: Applicant's Health Care Professional completes, signs, and dates Section 4.
Under this section and for the purpose of this reduce fare program, a Person with a Disability is defined as an individual who, because of a disability/condition, cannot use the city's transit system effectively without special facilities, planning, or design and significant difficulty. Having a disability alone does not assure eligibility for the disability reduce fare program. Please note that this is not an Americans with Disabilities Act (ADA) requirement & does not follow the ADA definition of a person with a disability.

** Individuals 65 years or older: Apply for a reduce fare Senior HOLO Card.
** Medicare Cardholders under 65 years: Apply for a reduce fare Medicare HOLO Card.
** Applicant receives SSI benefits or meets low income requirements: Apply for the Low Income Reduced Fare HOLO Card (call 808-768-7065 for details).

Section 3: Applicant Statement and Authorization to Release Medical Information

Read, Sign, and Date.

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

The Disability Reduced Fare Program is not an ADA requirement & does not follow the ADA definition of a person with a disability. Under this section and for the purpose of this reduce fare program, a Person with a Disability is defined as an individual who, because of a disability/condition, cannot use the city's transit system effectively without special facilities, planning, or design and significant difficulty. The supporting evidence must show how the disability affects the Applicant/Patient's ability to use public transit and specify what the Applicant/Patient needs to effectively use public transit based on the disability/condition. Please note that completing Section 4 does not assure that the Applicant/Patient will qualify for the disability reduce fare program.

Section 4 shall be completed, signed & dated by the Applicant's HCP who is licensed in the State of Hawaii and only in the fields covered by their license. Acceptable License Types APRN, LCSW, MD, PSY, PT, OT.

Line 4a: Print your Patient's name.

Lines 4a1 or 4a2: Select qualification category of your Patient.

INSTRUCTION SHEET – Side 2
Disability Reduce Fare Program Application

<u>Section 4: Supporting Evidence of Disability by a Health Care Professional (HCP) - continued</u>

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 your Patient's inability to effectively use the city's transit system without special facilities, planning, or design; and significant difficulty.

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 one month; limited-english 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 your Patient needs to effectively use the city's transit system due to the disability/condition specified in 4b.

Line 4d: 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 1 month.

Box 4e: Print Name, Address, Phone No., License Type & Number, License Expiration Date.
Use Agency stamp to identify Agency or Print Agency Name if Agency does not have a stamp.
Signature of HCP to certify Applicant is their patient and information provided is true & correct.
Date of signature. Digital signatures and faxed copies are not accepted.
Transit Pass Office may conduct follow-up verification of signature.

<u>APPLICATION PROCESS</u> <u>(Use only black or blue ink to complete application)</u>

Applicant shall submit the completed/signed application <u>IN-PERSON</u> at the Transit Pass Office.

Location: Kalihi Transit Center, corner of Middle St. and Kamehameha Hwy.
Phone No: 808-848-5555 (press 5)
Office Hours: Monday to Friday, 7:30 AM to 4 PM, closed on City Holidays
Be in line by 3:30 PM as the office closes promptly at 4 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 Health Care Professional date in Box 4e.

An official, valid picture identification (ID) is required for proof of identity, birthdate, and *Hawaii resident status. Acceptable forms of ID include driver's license, state ID, passport, permanent resident/resident alien ID, federally recognized Indian tribal ID. *Hawaii residency maybe supported by other documentation.

Only cash or credit card are accepted for payment.

Applicants who meet the eligibility requirements will be issued a Disability Reduce Fare HOLO Card with their photo by the Transit Pass Office. For eligibility under Section 2a, expiration is four (4) years from issue date and for eligibility under Section 4, the expiration date is based on the Health Care Professional date in Box 4e: Four (4) years for Permanent disability and expected duration on Line 4d for Temporary disability.

Applicants may appeal determinations that they do not qualify for the disability reduce fare by contacting the Department of Transportation Services (DTS) within 30 calendar days of the determination date by calling 808-768-8371 or emailing thebusstop@honolulu.gov to obtain instructions on filing an appeal with DTS.

APPLICATION - DISABILITY REDUCE FARE PROGRAM – Side 1
Transit Pass Office – Telephone: 808-848-5555 press 5
Located at Kalihi Transit Center – Corner of Middle St. & Kamehameha Hwy.

SECTION 1: APPLICANT INFORMATION (see Instructions - use black or blue ink only)

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 Reduce Fare HOLO Card.
Applicant is a Medicare Cardholder under 65 years old, apply for a Medicare Reduce Fare HOLO Card.
Applicant receives SSI benefits or meets low income requirements: Apply for the Low Income Reduce Fare HOLO Card (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 supporting evidence under Section 4 clearly demonstrating Applicant qualifies as person with a disability for the purposes of this reduce fare program. This is not an Americans with Disabilities (ADA) requirement & does not follow the ADA definition of a person with a disability.

SECTION 3. APPLICANT STATEMENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I acknowledge: **1)** if my eligibility is under 2b, having a disability alone does not automatically qualify me for the reduce fare - supporting evidence in section 4 determines whether or not I qualify for the disability reduce fare program, **2)** false information may invalidate my HOLO card, **3)** my application will be rejected if incomplete or submitted after 30 calendar days of the Health Care Professional date in 4e.

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

Health Care Professional: License Type & No:____________________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 - Resident Only: ☐ Monthly Pass, ☐ Annual Pass

☐ Application Not Processed: Reason: ____

Signature: ________________________________ Date: ____________________
(PROGRAM COORDINATOR)

Side 2 – Disability Reduce Fare Application (use black or blue ink only)
To Be Completed by the Health Care Professional (see Instruction Sheet)

SECTION 4: SUPPORTING EVIDENCE OF DISABILITY BY A HEALTH CARE PROFESSIONAL (HCP)
Supporting evidence of disability for the purposes of this disability reduce fare program: 1) does not follow the ADA definition for a person with a disability & is not an ADA requirement, 2) shall be only in the fields covered by the HCP's State of Hawaii License, 3) does not assure that the Applicant will qualify for the disability reduce fare program. When the supporting evidence clearly demonstrates that the Applicant qualifies as a person with disability for the purposes of this application, a disability reduced fare HOLO card will be issued.

4a. To be eligible for this reduce fare program, a Person with Disability is defined as an individual who, because of a disability/condition, cannot use the city's transit system effectively without special facilities/planning/design and significant difficulty. I certify that the Applicant (Name) ____is my patient and may be eligible for the Disability Reduce Fare Program under one of the following categories and requires special facilities, planning, or design to effectively use the city's transit system without significant difficulty as provided in 4c.

☐ **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/design the Applicant needs to use city transit.

____

4d. ☐ Permanent or ☐ Temporary: Expected duration of disability: _____mos. (not to exceed 24 mos.)

4e. HCP Certification. As a 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. I understand providing false information on this application form are grounds for Licensing sanctions under HRS Chapter 436B.

Name: ____ **Phone No: (   )** ______________

License No: _________________________________**(Type & No.) 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. HOLO Card expiration date is based on this date.**

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