Expiration Date _____

Application for GoTriangle
Disabled Passenger Identification Card

Applicant's Name and Address (please print)

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____ Apt#: _____

City: _____State: _____ Zip Code: _____

Telephone Number: ( ) _____- _____

Date of Birth: _____ / _____ / _____

Check the category under which you are applying for this ID Card:

NOTE: Categories 1-5 require you to present your identification card to prove your participation of eligibility in the program checked below.

1. ___ Age (65 and over)
2. ___ Medicare Identification Card (white card with red and blue stripes)
3. ___ Braille Institute Identification Card
4. ___ Disabled Veteran Service - Connected Identification Card
5. ___ ADA-eligible with another transit system
6. ___ Disability card with another system

If Categories 1-6 do not apply to you, check 7 and follow specific instructions.

7. ___ Medical Disability (Give this application to your health care professional to complete based on Eligibility Criteria).

DEFINITION

The ADA defines the term "disability" with respect to an individual as:

"(A) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment."

I hereby apply for a GoTriangle Disabled Passenger ID Card. I authorize my health care professional to provide medical information. If my application is approved, I agree to abide by GoTriangle's fare policies. I understand that GoTriangle will make the final determination of my eligibility for reduced fare. I declare, under penalty of perjury under the laws of the State of North Carolina, that the responses I have given are true.

Applicant's Signature: _____Date: ____/____/____

Mailed_____ **Pick up**_____ (check one)

After this application has been completed, bring it with you to GoTriangle's RTC (Regional Transit Center) located at 901 Slater Road, Durham, NC 27703 to have your ID card made. Identification cards will be made on the first and third Tuesday and Thursday of each month between 9 a.m. and noon. The first card will be issued for free. If you lose your card, it will be replaced at a cost of $5. If you have any questions, please call the office at 919-485-7433.

PLEASE CHECK WHICH OF THE REQUIREMENTS BELOW MEET YOUR ELIGIBILITY CRITERIA:

___ Visual impairment such that: (a.) vision in better eye is 20/200 or less after best correction (b.) visual field is contracted of 10' or less from point of fixation or subtends an angle not greater than 20'

___ 50 percent bilateral hearing loss uncorrected by use of a hearing aid

___ Musculosketetal impairment such as muscular dystrophy, osteogenesis imperfecta, or severe rheumatism or arthritis of Therapeutic Grate III, Functional Class III, or Anatomical State III

___ Cardiovascular impairments of Fuction class III or IV or Therapeutic Class C, D, or E

___ Respiratory impairment Class 3 or greater

___ Amputation of or anatomical deformity (due to vascular or neurological deficits, traumatic loss of muscle mass or tendons, or x-ray subluxation) or

instability of: both hands; one hand and one foot; one lower extremity at or above torsal region

___ Neurological disorder due to brain dysfunction or damage to the central nervous system, including cerebral palsy resulting aberration of motor functions

___ Paralysis, incoordination or functional motor deficit in any two limbs due to brain, spinal, or peripheral nerve injury

___ Emotional disturbance, including autism, either to the extent that applicant is living in a board and care facility, or at home under supervision

___ Epilepsy (convulsion disorder) involving impairments of consciousness that occur more frequently than once a month despite prescribed treatment

___ Any other disability you consider will restrict mobility. Please detail below or attach an explanation to this application:_____

_____

_____

_____

EXCLUSIONS: Persons are specifically excluded from eligibility whose sole incapacity is:

*** Pregnancy**

*** Obesity**

*** Acute or chronic alcoholism or drug addiction**

*** Contagious disease**

HEALTH CARE PROFESSIONAL CERTIFICATION:

In my professional judgment, this applicant's disability (please refer to the FTA Act definition on page 1) is:

(Check one only) ____ Permanently Disabled ____ Temporarily Disabled for ____ Months

(Note: ID cards will not be issued for less than six months or more than three years.)

Name: (Please Print) _____ Date: ____/____/____

Address: _____City: _____

State: _____ Zip Code: _____ Telephone: ( ) _____- _____

North Carolina Professional License Number: _____

I understand that failure to certify disabilities in accordance with the above guidelines will result in cancellation of my certification privileges. I hereby declare under penalty of perjury that the information provided is true and correct.

Health Care Professional (Signature):

_____