Potomac and Rappahannock Transportation Commission

14700 Potomac Mills Road, Woodbridge, VA 22192-6811
(703) 730-OMNI (6664)

Potomac and Rappahannock Transportation Commission

OmniLink/OmniRide Reduced Fare Card Eligibility Application

PART I to be completed by applicant.
PART II, on the reverse, to be completed and signed by a medical certifier, if required
Completed form should be mailed to PRTC, faxed to (703) 583-1702 or converted to an electronic file and e-mailed to *Omni@OmniRide.com*.

Name_____

Address_____

City_____ State_____ Zip_____

Telephone: Day (_____)_____ Evening (_____)_____

Male _____ Female _____ Date of Birth_____

Check all that apply:

[ ] Wheelchair [ ] Walker [ ] Service Animal (If other than dog, specify) [ ] Companion

[ ] Other, please explain:_____

_____

Do you require curb to curb service (PRTC does not provide door-to-door service)? [ ] Yes [ ] No

If yes, please explain:_____

_____

I am eligible to receive a Reduced Fare Card for the following reason(s):
[ ] I am age 60 years or older. ***(Attach a photocopy of a government-issued photo ID showing date of birth.)***
[ ] I have a mobility limitation or other disability. ***(Must have a medical certifier complete the reverse side.)***
[ ] I am a Medicare cardholder ***(Attach a photocopy of your Medicare card.)***

Please note: Reduced fare is valid on the Cross-County Connector and OmniLink bus services all day. Reduced fare is valid on OmniRide and Metro Direct bus services between the hours of 9:30a.m. – 3:00p.m. and after 7:00pm. If you have read this statement and understand, please sign and return the completed application to the above address.

I certify that the information provided herein is true and accurate to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any information will lead to the possible revocation of my certification.

_____ _____

(Signed) **(Date)**

PART II

Part II to be completed by a physician or any one of the following state or nationally certified professionals: Physical Therapist, Occupational Therapist, Rehabilitation Counselor, Registered Nurse, or Social Worker.

Eligibility Criteria: Please circle the eligibility criterion that pertains to the applicant.

A. Is required to use a wheelchair.

B. Has an impairment that prohibits standing alone for ten (10) minutes or more and requires the use of a crutch, cane, brace, walker, or other assistance.

C. Has an impairment that prohibits holding coins, tokens, or dollar bills or grasping stanchions or hand rails.

D. Cannot climb a flight of three (3) steps with an eight (8) inch rise, and also cannot walk one hundred yards on a level surface of grade without pause.

E. Is legally blind and unable to use mass transit. The definition of legal blindness is "central visual acuity of 20/200 or less in both eyes with best correction or visual field restriction of 20 degrees or less."

F. Has a diagnosis of mental retardation or development disability, head injury, or Alzheimer's Disease or related disorders, and has a cognitive impairment (inability to follow verbal, written, or pictorial directions) which causes disorientation or confusion while using mass transit, or demonstrates problematic stimulation such as crowds and noise.

G. Pregnancy that prohibits standing in a moving vehicle for ten (10) minutes or more.

H. Deaf or hard of hearing. (This guideline **must** be certified by either a licensed audiologist or a licensed otolaryngologist who is relying upon an audiogram for diagnosis): An individual whose hearing loss is 70 dba or greater in the 500, 1000, 2000 KHz ranges in both ears, regardless of the use of hearing aids.

Is the disability permanent? _____ Is the disability temporary? _____

If temporary, for how long (in months)? _____

Do any of the following pertain to the applicant?

	Yes	No
1. Has a medical condition that prevents him/her from using a seat belt.	____	____
2. Must travel with an escort or companion. (If "Yes", applicant will be required to travel with an escort at all times.)	____	____
3. Requires the assistance of a service animal in order to travel.	____	____

This information reflects my professional judgment that the applicant is eligible according to the criteria established here.

Certifier's Name: _____

Profession: _____

Address: _____

Telephone Number: _____ Registry/State Certification Number: _____

Certifier's Signature: _____ Date:_____

To be completed by PRTC

Authorized by:_____ Permit Number: _____

Date: _____