City of Annapolis
Transportation Department
308 Chinquapin Round Road
Annapolis, MD 21401-4007

Transit@annapolis.gov • 410-263-7964 • 410-269-0674 • Fax 410-263-4508 • www.annapolis.gov
Deaf, hard of hearing or speech disability - use MD Relay or 711

Application for the Annapolis Transit's Disabled Reduced Fare Program

This information will be used to determine the applicant's eligibility for the Annapolis Transit Reduced Fare Program for people with disabilities. Annapolis Transit will assess all information provided and determine eligibility and duration for participation in the Annapolis Transit Reduced Fare Program.

To qualify as a disabled individual, the applicant must, by reason of illness, injury, congenital malfunction, or other disability, be unable to utilize public transit as effectively as others.

Conditions that do not qualify include: pregnancy, obesity, controlled epilepsy, and contagious diseases which pose a danger to other passengers.

The applicant must fill out Section 1 and have his/her physician or healthcare professional fill out and sign Section 2 of this application.

SECTION 1: Applicant Information and Release

First Name: _____ Middle Name: _____ Last Name: _____
Gender: Male: _____ Female: _____
Street Address: _____ Apt. _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Telephone Number: _____
Current Disabled I.D. Holder: Yes_____ No_____

I hereby authorize my physician or health care professional completing this application to release to the Annapolis Transit information about my disability in order to verify my eligibility for a Reduced Fare I.D. card.
I hereby certify, under the penalties of perjury, that the information given above is true and correct.

Signature of Applicant: _____ Date: _____

SECTION 2: Medical Certification

Section 2 is to be completed by a licensed physician or health care professional. Information on this form will remain on file with the Annapolis Transit and is not subject to public review.

Physicians and Healthcare Professionals

Applicants who are eligible for the reduced fare program must meet the following definition: "individuals who, by reason of illness, injury, age congenital malfunction, or other permanent or temporary incapacity or disability, including those who are unable without special facilities or special planning or design to utilize public transportation facilities and services as effectively as persons who are not so affected."

The criterion for eligibility is not the applicant's "medical status" per se; it is the functional ability of the applicant to use regularly scheduled Annapolis Transit service. If the applicant is able to use such service but experiences extreme difficulty in doing so due to his/her medical condition, he/she is eligible. If the functional limitation that results from the medical condition is presently corrected by medical treatment, such as medication or prosthesis, the applicant does not qualify. If a temporary (up to one(1) year) qualifying condition exists, please describe the nature and expected duration. If the condition persists longer than the projected date, the applicant may re-apply. Low income or drug or alcohol addiction alone does not qualify an individual for reduced fare.

Physician/Healthcare Professional's Name:

_____

Facility Name:

_____

License/Certification Number: _____ State: _____

Board Certification Affiliation: _____

Street Address:

_____

City: _____ State: _____ Zip: _____

Telephone Number: (W)_____ (C)_____ Fax: _____

Email Address:

_____

1. Disability

Provide detailed and specific explanation of applicant's disability and how it specifically impairs his/her ability to use Annapolis Transit's transit services.

_____
_____
_____
_____
_____
_____
_____

2. What is the expected duration of the disability?

_____ Temporary: Short-term conditions lasting up to 12 months. Please indicate timing below:
_____ month(s)

_____ Permanent: Conditions with no expectation of improvement.

Verification and Authorization:
I hereby certify, under the penalties of perjury, that the information given above is true and correct. I understand that the Annapolis Transit will rely upon this information in making a determination as to the eligibility of participation in the program.

_____
Printed Name of Physician/Healthcare Professional

_____
Signature of Physician/Healthcare Professional

Office Use Only
Card Number: _____
Exp. Date: _____Category: _____
Approved By: _____
Issue Date: _____

_____
Date

Mail to:
Annapolis Transit Reduced Fare Program
308 Chinquapin Round Road
Annapolis, MD 21401
410-263-7964