County of Hawai'i Mass Transit Agency Application Form for Hele-On Bus Disability Identification Card

Applicant's Name				
Last	First		M.I.	
Mailing Address				
P.O. Box or Street	City	State	Zip Code	
Phone No.:	Identification: (check one) HI	Driver's License	HI ID	
Other ID (Specify):	Date of Birth	Gender:	Male Female	
<u>Term</u> :	s of Usage and Release of Medi	cal Information		
I declare under penalties of penal law and accurate and that I have not know have read and understand the terms of to abide by them.	vingly given a false statement or	given information	which I know to be false. I	
I also authorize my Physician to releas information regarding my disability wi services on the Hele-On Bus.			•	
I understand that the Hele-On Bus DIC purchasing discounted bus tickets or does not allow me to ride for free. If Mass Transit Agency immediately. If i (2) years. I must reapply to be eligible replacements, I must complete another	monthly pass and must be visible my DIC is lost or stolen, it cannot it is found and misused, the user a for this program, if available, p	ole to the bus opera ot be used by anyor will be fined. The rior to expiration of	ator when I board. The DIC ne else and I must notify the DIC will be valid up to two	
Applicant's (or Authorized Representa	atives) Signature:			
		Date: _		
In order for us to evaluate your applic	ration for a DIC, you must have y	our Licensed Practi	icing Physician certify that	

In order for us to evaluate your application for a DIC, you must have your Licensed Practicing Physician certify that you are eligible for this program. Only Physicians are able to certify this form. Once the information on the reverse side of the page is completed by your Physician, the completed form must be submitted to the Mass Transit Agency for processing. If any information is missing, the form will be returned to you. You will be notified of our determination within 21 days of receiving your completed application. Your Hele—On DIC will be mailed to you upon approval within the 21 day determination period. In the meantime, you must pay the \$2.00 bus fare when riding the Hele-On Bus (until you receive the DIC).

Please send the completed application form and along with a copy of your photo I.D. to:

County of Hawai'i Mass Transit Agency 25 Aupuni Street Hilo, HI 96720

Telephone: (808) 961-8744

Fax: (808) 961-8745

Email: <u>heleonbus@hawaiicounty.gov</u>

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TO BE COMPLETED BY A LICENSED PHYSICIAN

· —————	certify tha) under one of the follow	• •	ant qualifies for a He	ele-On Bus Disability	
	a physical or mental dis e, without difficulty or a	•	*	· · · · · · · · · · · · · · · · · · ·	cing such
 ···	an incapacity or disabiliory for the effective use only):	•	•		_
Boarding or Reading info	a flight of stairs or ramp alighting from a Hele-Or ormational signs; or re than 200 feet				
Description of Disability	y:				
Condition is	Permanent	Temporar	y (State Duration) _		
If YES, please list t Note: Only one PC	ant (PCA) is required for the name(s) of PCA(s): A is eligible to accompa \$\frac{5}{1.00}\$ or by using bus ti	ny the applicant at	time. PCA(s) may r panying applicant.	No ride the Hele-On bus at	: a
I understand that per H	IRS 291, Part III, if I as a	physician fraudule	ntly verify that	Applicant's Name	
•	oility to enable the applic of fraudulent verification			• •	
Physician's Name:	Last	Firs	<u> </u>	M.I.	
Mailing Address:			<i>,</i>		
	Street/P.O. Box	City	State	Zip Code	
Date:	Phone:		Medical License No.:		
The Mass Transit Agen	cy will review this certifi	cation to determin	e the applicant's eli	gibility for the Hele-Or	n Bus DIC.
Mass Transit Agency Use Or					
Approved Date Card No. Expiration		C	Denied Reason		