Sioux City Transit System
Proof of Eligibility for
Senior Citizen or Disabled Reduced Fare Photo Identification Card

Eligibility Criteria, Documentation Requirements, Procedures, and Application

Sioux City Transit's Proof of Eligibility Card is a photo identification card which provides eligible persons the opportunity to ride Sioux City Transit's fixed routes at a reduced rate. To be eligible, a person must be disabled OR be 62 years or older.

Proof of eligibility would be one of the following:

- **A current Medicare Card.**
- **A Certificate of Eligibility for ADA Paratransit Service is acceptable.**
- **For a person who is 62 or older, a photo I.D. with birth date would be acceptable.**

If a disabled person does not have a Medicare Card or Certificate of Eligibility for Paratransit service, the application included with this form may be filled out and signed by a physician and returned to the Sioux City Transit System as proof of eligibility.

The Sioux City Transit Proof of Eligibility Card/Photo Identification card must be shown to the bus operator when an individual boards a bus, prior to depositing the discounted cash fare or presenting a Disability or Senior ticket or the Senior Citizen/Disability Monthly pass. The reduced rates are valid during all days and hours that SCTS buses operate. The Sioux City Transit Proof of Eligibility Card/Photo Identification card must be shown to purchase a Senior Citizen or Disability ticket or the Senior Citizen/Disability Monthly pass. **The Reduced cash fare is 50% of standard fare.**

A. Eligibility Criteria and Documentation Requirements

1. Submit completed application and provide required documentation as described below:

- Individuals age 62 and older:
  Provide either Social Security Award letter, or photo ID with age documentation.

- Individuals with a disability:
  Must complete and bring Part One of application; and,
  Provide Certificate of eligibility for ADA Para transit service; or,
  Provide Medicare card; or,
  Complete and bring Application Parts One, Two, and Three signed by physician.

B. Questions and Information

- TELEPHONE: 712-279-6405 Sioux City Transit System Office
  FAX: 712-279-6407 Sioux City Transit System

- MAIL: Sioux City Transit System, 509 Nebraska Street, Sioux City, Iowa 51101

C. To Obtain the Photo Identification Card

- Bring completed application and documentation to:
  Martin Luther King Jr. Transportation Center, 505 Nebraska Street, dispatcher window.
  Hours: Monday – Saturday from 7:30 a.m. – 5:30 p.m.

SIOUX CITY TRANSIT SYSTEM -- REDUCED FARE APPLICATION

PART ONE - Applicant completes. **(PLEASE PRINT)**

NAME: ____
Last First Middle

Address ____
Number Street City State Zip

Birth Date ______/____/_______ Email __________________________________ Fax (   )________________________
Month / Date / Year Print

Home Phone: (   )________________ Cell Phone: (   )_____________ Care Taker (   )______________

Comments ____

____

PART TWO – Applicant must sign and date prior to the completion of PART THREE.

____
Applicant Signature Date

agrees to release the following information to Sioux City Transit for the purpose of Half-Fare eligibility certification for fixed route buses.

PART THREE - Physician completes.

Disability – A Transportation Disability is any incapacity or disability which prevents an individual from using transportation facilities and services as effectively as a person not so affected. **An individual will be considered "Transportation Disabled" and eligible to receive all present and future benefits, if the individual meets at least one of the Criteria listed below and obtains a physician's certification that the disability relates to the Criteria lasting for more than 12 months**. An individual who meets one of the Criteria; receives proper certification, and has a disability lasting at least three months, but no more than 12 months may apply as an individual "Temporarily Disabled".

INSTRUCTIONS: **please check as many Criteria as are applicable; sign and date on Page 2 of application.**

_______ Possesses a valid Medicare Card and is under 65 years of age - 12 month certification.
_______ Has any condition requiring use of wheelchair, walker, crutches, leg/foot braces or other mobility aid devices.
_______ Has one or more missing limbs or critical part thereof: use of prosthetic devices.
_______ Is legally blind; a person whose vision in the better eye after best correction is 20/200 or less; and, a person whose visual field is contracted (commonly known as tunnel vision).
_______ Has a severe hearing impairment, deafness or hearing incapacity that may make an individual insecure in public areas because the individual is unable to communicate or hear warning signals including only those persons whose hearing loss is 90 dba or greater in the 500, 1,000, 2,000 Hz ranges.
_______ Has a cardiovascular or respiratory condition which significantly interferes with coordination, endurance, or strength. (Eligibility criteria for respiratory is Class III or above.)
_______ Has a neurological condition which significantly interferes with coordination, strength, or endurance such as polio, cerebral palsy, multiple sclerosis, or paralysis.

Both pages of application must be completed for SCTS to process.

_______ Has a muscular-skeletal condition which significantly impairs motor skills, such as muscular dystrophy, severe rheumatism or severe arthritis affecting two or more limbs. American Rheumatism Association criteria may be used as a guideline for the determination of arthritic handicap. Therapeutic Grade III or worse and Functional Class III or worse and Anatomical State III or worse are evidence of arthritic handicap.

_______ Mental Retardation: refers to sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior (a general guideline is an IQ more than two standard deviations below the norm). Also applies to adults who, by reason of illness or accident, suffer mental retardation.

_______ Mental Disability: emotionally disturbed - To the extent of total disability and

1) living in a board and care home receiving State, county or federal financial assistance and participating in a state, county or federally funded work activity center/workshop; or

2) living at home under supervision and may or may not receive state, county or federal financial assistance, and participating in a state, county or federally funded work activity center/workshop (A 12-month certification).

_______ Dialysis Treatment – must use kidney machine.

_______ Epilepsy: clinical disorder involving impairment of consciousness, characterized by major motor seizures (grand mal or psychomotor) substantiated by EEG, occurring more frequently than once a month in spite of prescribed treatment with a) Diurnal episodes, or b) Nocturnal episodes showing residuals interfering with day time activities (A 12-month certification).

_______Temporary disability: at least 3 months, not more than 12 months projected to last until ______/_____/______.
Month / Date / Year

COMMENTS____

____

HEALTH PROFESSIONAL CERTIFICATION

I hereby certify, due to checked Criteria, the above named applicant is unable to utilize mass transit facilities and services as effectively as people who are not so affected &, to the best of my knowledge, the above is true & correct.

1. Physician ____ / ____
Print Name Signature

Address ____
Number Street City State Zip

Telephone _______________________ Fax ________________________ Email _____________________________
Print

OR

2. Agency _____________________________________Telephone __________________Email __________________
Print Agency Name

Address ____
Number Street City State Zip

Authorized Person ____________________________________ / ____
Print Name / Title Signature Name / Title

Both pages of application must be completed for the SCTS to process.