# REGIONAL TRANSPORTATION DISTRICT
# Special Discount Card

**What is a Special Discount Card?**

The Special Discount Card (SDC) offered by RTD provides fare reduction for people with disabilities. This guide will provide general information on the program. For additional information, please contact RTD at 303-299-2667.

**Eligibility Requirements**

In order to be eligible for an SDC, you must provide proof of your disability. One of the following original items will be accepted as proof of disability:

- Medicare Card
- Social Security Disability Insurance or Supplemental Security Income (Provide a current TPQY form or Notice of Award letter which indicates that you are disabled and that you have received benefits within the last twelve months.)
- V.A. Letter (official letter on V.A. letterhead that states at least a 50% disability)
- Healthcare Provider Statement Form (See attached form; form must have been signed and dated by the healthcare provider within the last three months.) **Healthcare Professionals, if applicant meets the eligibility criteria, please attach a statement on your professional letterhead noting the name and diagnosis of the applicant and describing in detail how the applicant meets the eligibility criteria.**

**No other proof of disability will be accepted. No photocopies and faxes will be accepted.**

**How to Apply**

Bring your proof of disability, $2.00, and, photo identification to one of the following RTD locations:

- 1600 Blake Street, Denver, Monday - Friday, 9:00 a.m.-1:30p.m and 2:30p.m. - 4:00p.m.
- 1400 Walnut Street, Boulder, Monday Only, 12:00 noon - 2:00 p.m.
- 910 Longs Peak Avenue (Longmont Senior Center), Longmont, Second Monday Each Month, 3:00 p.m.-4:00 p.m.

**Note: Special Discount Card photos will not be taken on the following days: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Day after Thanksgiving, and Christmas Day.**

RTD will accept photo identification issued by a state or federal agency, such as a state driver's license or V.A. card. **Photocopies of I.D. cards and other forms of photo identification will not be accepted.**

Upon approval of your eligibility, you will be issued an SDC, which will entitle you to use fixed-route bus service by paying a reduced-cash fare or purchasing a monthly pass at a discounted rate.

**Lost Cards or Damaged Cards**

To replace a lost or stolen SDC, go to the locations above at the times listed. The first card will be replaced at a charge of $2.00. Each additional card lost will be replaced at a charge of $5.00 to a maximum of five cards replaced in one year. Damaged cards will be replaced at no charge; however, the damaged card must be presented at the time of being reissued.

# RTD SPECIAL DISCOUNT HEALTHCARE PROVIDER FORM

## Applicant Section

**Disability Affirmation:** I am disabled as described in the Healthcare Professional Section of this application. I affirm under penalty of perjury that all statements made by me on this application and to the physician or other licensed professional named on the form, upon whose opinion RTD relies for determination of eligibility status, are true and complete. I understand that all statements made in this application may be subject to investigation and verification, that material misstatement or fraud will disqualify me for the Special Discount Program. I understand that RTD will rely upon the statements made in this application, whether or not RTD has investigated the statements contained in this application. RTD may, at its discretion, waive requirements on a case-by-case basis. I understand that RTD may discontinue or change its Special Discount Program without notice. I understand that it is a crime to allow anyone else to use my Special Discount Card or for me to continue to use the card if I am no longer disabled as defined by the Special Discount Program.

______________________________________________
Print Applicant Name

______________________________________________
Signature of Applicant Date

**Medical Authorization:** I authorize the release of any medical information necessary to process this application.

______________________________________________
Signature of Applicant Date

______________________________________________
Address City State Zip Code

______________________________________________
Phone Number Social Security Number

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**Healthcare Professional Section** (Please type or print in ink.)

**Healthcare Professional:** ______________________________________________
Name (Last, First, Middle Initial)

______________________________________________
Office Address

______________________________________________
City State Zip

______________________________________________________
Print Applicant (Patient's) Name

Check one: (You must be one of the following types of licensed healthcare professionals in order to complete this form.)

❏ Physician ❏ Registered Nurse ❏ Optometrist
❏ Audiologist ❏ Psychologist ❏ Psychiatrist
❏ Occupational Therapist ❏ Physical Therapist

______________________________________________________
License Number Telephone Number

❏ Licensed Social Worker or Licensed Special Education Teacher (May complete the Mental Retardation and/or Mental Impairment Section only. In the statement of eligibility, please state your qualifications and basis for making the disability judgment.)

______________________________________________________
License Number Telephone Number

**Type of Disability:**

I have examined the applicant (fully identified in the Applicant's Section of this application). It is my opinion that he/she is a "disabled person" within the meaning of the terms set forth in this document. The impairment is the following:

**Check all that apply:**

❏ Blindness – There is central visual acuity of 20/200 or less in the better eye with the use of correcting lenses. An eye which, accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle of greater than 20 degrees, shall be considered as having central visual acuity of 20/200 or less.

❏ Hearing Impairment – With hearing aids, hearing is NOT restored to one of the following levels:

> ❏ Average hearing threshold sensitivity for air conduction of 90 decibels or greater, and for bone conduction to corresponding maximum levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000, and 2000 Hz.
>
> ❏ Speech discrimination scores of 40% or less in the better ear.

❏ Ambulatory Disability/Disorder of Gait – From whatever cause, the person is unable to move about without a walker, wheelchair, wheelchair stroller, a crutch, crutches, or a cane at all times. The word "unable" is used in its literal sense. The fact that one of these mechanical aids facilitates movement is not sufficient.

The applicant is incapable of moving about without use of the following aid:

❑Wheelchair ❑Wheelchair Stroller ❑Cane ❑Walker ❑Crutch (es)
❑Other Ambulatory Aid (please describe) ______________________________

❑Loss of Both Hands – By reason of amputation or anatomical deformity, the person lacks both hands.

❑Mental Retardation and/or Mental Impairment – The scores specified below refer to those obtained on the W.A.I.S. and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.

❑The person is mentally incapacitated such that he/she is dependent upon others for personal needs (e.g., toileting, eating, dressing, or bathing) AND is unable to follow directions such that the use of standardized measures of intellectual functioning is precluded.

❑Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 59 or less.

❑Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 60 to 70 AND is unable to perform routine repetitive tasks OR has a physical or other mental impairment imposing additional and significant limitation of mobility or gait.

❑Serious Mental Illness – The applicant currently meets the criteria for a DSM-IV diagnosis other than (i) alcohol or drug disorders, (ii) developmental disabilities, (iii) dementia or mental disorders due to general medical conditions, except those with predominant psychiatric features, or (iv) social conditions (V-codes): **AND** experiences substantial impairments in functioning due to the severity of his/her clinical condition. The applicant experiences substantial dysfunction in a number of areas of role performance or is dependent on substantial treatment, rehabilitation, and support services in order to control or maintain function capacity. Further, the person has experienced substantial impairments in functioning due to mental illness for an extended duration.

**Duration of Impairment:** I estimate that the duration of the impairment will be:

❑Permanent (five or more years)
❑Temporary (more than three months but less than five years)
Indicate anticipated length of impairment ______________________________

**Statement of Eligibility:** **<u>If applicant meets the eligibility criteria, please attach a statement on your professional letterhead noting the name and diagnosis of the applicant and describing in detail how the applicant meets the eligibility criteria. Photocopies and form letters are not acceptable. This statement is required in order to process this application.</u>**

______________________________________________________________

**Healthcare Professional's Signature** **Date**