Reduced Fare Eligibility Application

LONG FORM WITH DOCTOR'S AUTHORIZATION

The Orange County Transportation Authority (OCTA) and OC Bus offer discounted prices on transit fares for eligible individuals, including senior and disabled individuals. Available programs and pricing are available at OCTA.net/fares or by contacting OCTA.

Once certified as eligible for a reduced fare, individuals will be able to purchase and use the associated discounted fare, including onboard cash fare, reduced fare transit passes, and discounted fares within OCTA's account-based Wave fare system.

The Reduced Fare program is part of OCTA's Wave fare system, which is offered as physical smartcard or mobile application. The reduced fare status will be applied to a single smartcard or mobile application registered to a customer's account. Transit fares charged to the selected Wave card will automatically be discounted once a Reduced Fare application is approved.

ABOUT THIS APPLICATION

This application form (Medical Certification) is intended for applicants who will require a certification from a medical professional for their disability.

You should NOT use this form if:

- You already have a current (non-expired) Reduced Fare or OC ACCESS ID issued by OCTA
- You qualify for another Reduced Fare that does not require medical certification
- You have another current ID or document that establishes your eligibility, such as a Medicare ID card, Department of Motor Vehicles Disabled Person Placard, Braille Institute ID, Service Connected Disabled Veteran card, or a Disabled ID card issued from another transit agency.

Information about other types of Reduced Fare applications is available on OCTA.net/Apply.

HELP WITH THIS APPLICATION

If you have any questions regarding this application, please contact OCTA by calling (714) 560-5596 (Monday through Friday from 8 a.m. to 2 p.m.), emailing OCTA at customers@OCTA.net, or by visiting OCTA.net/Apply.

SUBMITTING THIS APPLICATION

To complete this application, you will need to create a Wave account at OCBus.com/Wave, submit a completed Reduced Fare application, including the certification signed by a medical professional, and include a recent photo. Photos must be a clear, passport style photo of just the applicant. Photos can also be taken in-person at the OCTA Store.

Completed Reduced Fare applications can be submitted online at OCTA.net/apply, returned in-person at the OCTA Store, or sent to OCTA by mail.

Online	In-Person	OCTA Store Hours	By Mail
OCTA.net/Apply	OCTA Store 600 S Main St Orange, CA 92868	Monday - Friday 8 a.m. - 5 p.m.	OCTA Reduced Fare PO Box 14184 Orange, CA 92863-1584

APPLICANT INFORMATION (REQUIRED)

First Name | Middle Initial | Last Name

Street Address | Unit or Apartment Number

City | State | ZIP Code

Telephone Number | Email Address | Date of Birth

I declare under penalty of perjury under the State of California that the information I have given is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated.

Applicant's Signature | Date

APPLICATION PROCESS

After your completed application is reviewed and all information is verified, and if your application is approved, OCTA will provide the Reduced Fare benefit to your selected Wave option (either a physical card or mobile app). If a physical Wave card is requested, the first card provided to each applicant will be free.

If your application is denied, you will receive written notification from OCTA that will include the reason(s) for the denial. You may appeal OCTA's denial of your eligibility by submitting a written appeal to OCTA within 14 days of the date of the denial notice from OCTA. Your appeal should explain the reason(s) for your request for a review and reconsideration of your eligibility.

WAVE ACCOUNT INFORMATION (REQUIRED)

Existing Wave Account Email

How will you be using your Reduced Fare on Wave? (Please select only one)

☐ I will use the Wave mobile app

Please provide your Wave virtual card number.

Wave Virtual Card Number

☐ I will use a physical Wave card

If you already have a physical Wave card, please provide the card details below. Otherwise, a Wave card will be mailed to you.

Wave Card Number | Printed PIN Number

MEDICAL DISABILITY CRITERIA

Qualified healthcare professionals who may certify disabilities listed on the following page are listed below:

M.D. & D.O. - All Classifications	Optometrist - Classification 11
Chiropractors - Classifications 1 2 3	Audiologist - Classification 12
Podiatrist - Classifications 1 2 3 4	Clinical Psychologist - Classifications 13 14

ELIGIBLE MEDICAL DISABILITIES

MOBILITY IMPAIRMENT

1 **Non-Ambulatory:** Requires the use of a wheelchair.

2 **Mobility-Aided:** Requires use of an AFO or larger leg brace, walker, or crutches to achieve mobility

3 **Amputation:** Anatomical deformity or amputation of hand(s) and/or feet or loss of major function.

4 **Arthritis:** Therapeutic Grade III or worse, Functional Class III or worse or Anatomical Grade III or worse

5 **Stroke:** Causing pseudobulbar palsy, sustained functional motor deficit of gross/dexterous movement or gait, or ataxia affecting two or more extremities

PHYSICAL IMPAIRMENT

6 **Respiratory:** Class III or greater

7 **Cardiac:** Vascular impairments of Functional Class III or IV and Therapeutic Class C, D or E

8 **Dialysis:** Individuals who require kidney dialysis to live.

9 **Neurological Impairments:** As contained in *Disability Evaluation Under Social Security Publication*.

10 **Chronic progressive debilitating disorders:** Diseases that are characterized by chronic symptoms such as fatigue, weakness, weight loss, pain and changes in mental status, which interfere in daily living activities and significantly impair mobility.

- Progressive and uncontrollable malignancies
- Advanced connective tissue disease, such as Lupus eythematousus, sclerodema or polyarteritis nodosa
- Symptomatic HIV: (AIDS or ARC) in CDC defined clinical group IV, Subgroups A-E

VISION & HEARING IMPAIRMENT

11 **Visual Impairments:** No better than 20/200 after correction in best eye, or visual field is contracted to 10 degrees or less from point of fixation or subtends to angle no greater than 20 degrees.

12 **Hearing Impairments:** Persons whose hearing loss is 70 dB or greater in the 1000 and 2000 Hz ranges.

MENTAL IMPAIRMENT

13 **Mental/Emotional:** Individual with a mental or emotional impairment listed in *Diagnostic and Statistical Manual V* of the American Psychiatric Association, the severity of which meets or exceeds standards outlined in the *Disability Evaluation Under Social Security Publication*. Disability must have been present for at least three months and be expected to continue for at least three months past the application date.

14 **Autism:** Syndrome consisting of withdrawal, inadequate social relationships, language disturbance and monotonously repetitive motor behavior.

MEDICAL RELEASE CONSENT (REQUIRED)

In connection with my application for a Reduced Fare, I hereby authorize the signing physician listed below to release to the Orange County Transportation Authority, medical or other pertinent information regarding my disability. The information released will only be used to verify my patient status and the designation of my disability category. I realize that I have a right to receive a copy of this authorization. I understand that I may revoke this authorization at any time. Unless revoked, this form will permit the health care professional certifying my disability to release pertinent information for up to 60 days after the date appearing below.

Doctor's Full Name

Applicant Name (Print) | Applicant Signature | Date

MEDICAL PROFESSIONAL CERTIFICATION (REQUIRED)

I understand that failure to certify disabilities in accordance with the above guidelines will result in cancellation of my certification privileges. I hereby declare under penalty of perjury that the information provided is true and correct.

I hereby certify that the applicant's disability meets the criteria for a Reduced Fare. (Check all that apply.)

- ☐ 1 **Visual Impairments**
- ☐ 2 **Mobility-Aided**
- ☐ 3 **Amputation**
- ☐ 4 **Arthritis**
- ☐ 5 **Stroke**
- ☐ 6 **Respiratory**
- ☐ 7 **Cardiac**
- ☐ 8 **Dialysis**
- ☐ 9 **Neurological Impairments**
- ☐ 10 **Chronic Progressive Debilitating Disorder**
- ☐ 11 **Visual Impairments**
- ☐ 12 **Hearing Impairments**
- ☐ 13 **Mental / Emotional Disorders**
- ☐ 14 **Autism**

Please describe nature of applicant's disability.

Doctor's Full Name | License Number

Street Address | Suite or Office Number

City | State | ZIP Code

Office Telephone Number | Office Email Address

Doctor's Signature | Date

Doctor Recommended Reduced Fare Approval Period:

☐ 3 mo. ☐ 6 mo. ☐ 1 yr. ☐ 2 yr. ☐ 5 yr.