Bus .91
(REV. me)-web

PERSON WITH A DISABILITY BUS PASS APPLICATION

DEPARTMENT OF TRANSPORTATION SERVICES, CITY & COUNTY OF HONOLULU
Oahu Transit Services, TheBus Pass Office, 811 Middle Street, Honolulu, Hawaii 96819
Telephone: 848-4444

EXPIRATION DATE	
MONTH	

❑ Mr.
❑ Mrs.
❑ Ms.

❑ Male ❑ Female

Name: ____________________ (LAST) ____________________ (FIRST) ____________________ (MIDDLE INITIAL) Phone: ____________________

Address: ____________________ City: __________ State: __________ Zip: __________

Birthdate: ____________________ Date Applied: ____________________

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO PROCESS THIS APPLICATION.

NOTE. If applicant is unable to affix signature, "mark" to be witnessed by authorized agency personnel or notary public.

Signature: ____________________ Witness: ____________________

Do you have a MEDICARE card issued under Tale 11 or Title XVIII of the Social Security Act? ❑ Yes ❑ No

If yes, please attach a copy of the MEDICARE card.

Were you ever issued a Person with a Disability Bus Pass in Honolulu? ❑ Yes ❑ No

If yes, what is/was the expiration date? ____________________

Were you ever issued a TheHandi-Van card in Honolulu? ❑ Yes ❑ No

If yes, what is/was the expiration date? ____________________

FOR DEPT. USE ONLY-

DO NOT WRITE IN THIS BLOCK

❑ Application Approved

❑ Application Denied*

Pass Issued: ____________________

Duplicate: ____________________

Signature: ____________________ DTS (PROGRAM COORDINATOR) Date: ____________________

• Reason: ____________________

TO BE COMPLETED BY A LICENSED PHYSICIAN OR DTS AUTHORIZED AGENT.

ALL INFORMATION REQUESTED BELOW MUST BE COMPLETED OR APPLICANT WILL BE DISAPPROVED.
IF NONE APPLY, DO NOT SIGN.

I, ______________________________ , certify that the above-named applicant has an incapacity or disability which results in the inability to perform one or more of the following functions necessary for the effective use of the City bus system's facilities without significant difficulty as indicated by "X":

(1) **Negotiate a flight of stairs, escalator or ramp;**

(2) **Board or alight from a City transit vehicle;**

(3) **Use the City transit bus due to confusion or disorientation;**

(4) **Read informational signs; or**

(5) **Walk more than 200 feet.**

❑ **Permanent** ❑ **Temporary: Duration of Disability** ______________________________

Diagnosis of Disability: ______________________________

____

Name/Agency: ______________________ **Signature:** ______________________

Address: ______________________ **Phone Number:** __________ **Date:** __________