



Reduced Fare Program
ADVANTAGE

Please read the enclosed application carefully. The information you submit will be used to determine if you are eligible to receive a Reduced Fare ID card. There is no cost for the initial ID card; however there is a replacement fee. The card is renewed every three years by a new application.

Instructions:

1. Please **Print clearly** and fill out Part 1 and 2 of the application that applies to you.
2. Have your **Health Care Professional** complete and sign Part 3 of the application.
3. Return the completed application to:

**Reduced Fare Program Lost
& Found
455 N. Garland Avenue Orlando,
FL 32801**

If you have any questions regarding this program feel free to call us at:
(407)841-5969, Option 1.

Pictures are taken:
Monday – Friday
8:30 a.m. – 4:30 p.m.
3rd Saturday of the Month
9 a.m. – 1 p.m.

Reduced Fare Program Application
ADVANTAGE
PART 1
APPLICANT STATEMENT

For Office Use Only

File Number _____

Issued Date _____

Expiration Date _____

LAST NAME: _____ First: _____

STREET ADDRESS: _____

_____ COUNTY: _____ ZIP: _____

BIRTH DATE: ____/____/____ Phone: _____

Please answer the following questions:

Do you have a **Medicare** card? Yes _____ No _____

Do you receive a monthly **SSI Benefits** for a disability? Yes _____ No _____

Do you receive **Disabled Veteran Benefits**? Yes _____ No _____

Are you an ACCESS LYNX rider? Yes _____ No _____

(If you answer yes to any of the above questions please bring proof and do not complete Part 2 or 3.)

MENTALLY DISABLED

1. Are you mentally disabled? Yes _____ No _____

VERIFICATION OF ELIGIBILITY FORM (PART 3) MUST BE COMPLETED BY A HEALTH CARE PROFESSIONAL.

PHYSICALLY DISABLED

1. Are you physically disabled? Yes _____ No _____

2. Are you able to board a vehicle without assistance? Yes _____ No _____

3. Are you able to use the bus system for the general public? Yes _____ No _____

VERIFICATION OF ELIGIBILITY FORM (PART 3) MUST BE COMPLETED BY A HEALTH CARE PROFESSIONAL.

I certify that the above information is true and correct. I understand that if this application is approved, I will be eligible, to ride LYNX buses for the reduced fare. I must show my LYNX ID when boarding or paying a fare, otherwise I will be required to pay full fare.

Signature

Date

PART 2

To assist in determining eligibility for the LYNX Advantage Reduced Fare ID card, it may be necessary to contact a qualified professional to obtain specific information on how your disability affects your usage of the fixed-route bus service. Disability verification by a qualified professional does not guarantee eligibility for the LYNX Advantage Reduced Fare ID cards, but it can assist in the eligibility determination process. It is important that any professional who verifies another individual's disability be familiar not only with that person's particular disability, but also with the individual's ability or inability to travel on the fixed-route bus system.

Qualified Health Care Professionals

Licensed Physician
Rehabilitation Counselor
Orientation and Mobility Specialist
Case Manager

Physical Therapist
Occupational Therapist
Medical Social Worker

Please note: This form is to be completed by you the applicant, not by your health care professional.

I _____ authorize _____
Applicant's Name Name of Qualified Professional

Address

Phone

Agency (If Applicable.)

to release information concerning my disability and its affect on my ability to travel on the fixed-route bus system to LYNX personnel. I understand that I may revoke this authorization at any time by written notice.

Applicant's Signature

PART 3
VERIFICATION OF ELIGIBILITY

Applicant's Name: _____

The information you provide must be based solely upon the applicant having an actual physical or cognitive limitation.

MENTALLY DISABLED

Is the applicant mentally disabled? Yes _____ No _____

If yes please check the level of cognitive impairment.

Mild _____ Moderate _____ Profound _____ Severe _____

Diagnosis/Explanation: _____

PHYSICALLY DISABLED

Is the applicant physically disabled? Yes _____ No _____

If yes please describe the nature of the applicants' physical disability.

Diagnosis/Explanation: _____

PROFESSIONAL CERTIFICATION

I certify that the above named person has a physical or mental disability which makes it more difficult for him or her to use the public bus system and is thus deserving of a reduced fare identification card.

Signature Date

Professional License Number: _____ State Issued: _____

Print Name: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Ext. #: _____ Contact Person: _____

