FINNEY COUNTY TRANSIT
1008 N. ELEVENTH STREET
GARDEN CITY, KS 67846
620-272-3626 FAX: 620-271-6191
www.finneycountytransit.org

CITY LINK

HALF-FARE PROGRAM

ELDERLY*DISABLED*LOW INCOME

Individuals who qualify for City Link's Half Fare Program are entitled to ride regular fixed route buses for one-half the regular fare. A special Half Fare ID card will be issued to eligible individuals who have qualified for the service by completing the application form. **City Link's Half Fare ID card is required and must be shown when boarding the bus in order to receive reduced fare privileges. Medicaid cards and State of Kansas medical cards are not verification of eligibility.**

Who is Eligible?

The Half Fare Program is available for individuals who are 60 years of age or older, low income individuals as determined by SRS Food Stamp verification letter, and for those who have a physical or mental disability that is verified by a **qualified professional** such as: **physician(M.D. or D.O.), registered nurse, physical or occupational therapist, psychiatrist, psychologist, mental health counselor, vocational counselor, rehabilitation specialist, independent living skills trainer or ophthalmologist.**

How Do I Qualify?

1. Fill out and sign the Half Fare application. Persons 60 years of age or older must provide proof of age. Low Income is proven with SRS Food Stamp verification letter. Persons with disabilities who are not 60 years of age or older must complete and sign **Part I**, and must also have a qualified professional fill out and sign **Part II**.

2. Bring the completed and signed application form(s) and all other supporting documents (including a photo ID, a driver's license, Kansas ID, or birth certificate) to the Finney County Transit Center, 1008 N. 11th between 6:00 AM and 7:00 PM, Monday through Friday. The application will be processed and your eligibility will be determined. Upon acceptance into the program, you will be issued a Half Fare card.

Card Replacement

If your card is lost or stolen, please notify Finney County Transit immediately by calling 620-272-3626. Replacement ID's will be issued at a cost of $5.00 per card. Cards used improperly will be confiscated and privileges will be revoked. If you have any questions about the Half Fare Program, please call 620-272-3626 between 6:00 AM and 7:00 PM, Monday through Friday.

CITY LINK'S HALF FARE PROGRAM
APPLICATION FORM -PART I

Please make sure the documents are SIGNED and DATED.

Name: _____

Last First Middle

Address: _____

Street City Zip

Phone Number: _____

Date of Birth: _____

Month Day Year

I am applying for a City Link Half Fare ID card because:

CHECK ONE

A. I am 60 years old or older
Requires a valid driver's license, Kansas ID or Birth Certificate to verify age _____

B. My income is at or below Dept. for Children and Families Food Stamp Eligibility Guidelines
Requires a current Food Stamp verification letter _____

C. I have a legally documented disability
You must have a qualified professional fill out and sign Part II. _____

I certify that the information provided is true and agree to release this information to City Link for the purpose of obtaining a Half Fare card. I understand that the card is for my personal use and will not be transferred to any other person. I grant City Link permission to verify the information given on Parts I and II of this form.

_____ _____

Signature of Applicant Date

CITY LINK'S HALF FARE PROGRAM
APPLICATION FORM -PART II

To Be Completed By A Qualified Professional Only

To be eligible for the City Link Half Fare Program, your patient/client must have a physical or mental condition that falls within the medical criteria listed below. If you confirm that the patient/client is physically or developmentally disabled, that person will be eligible for reduced fares on City Link's public fixed route bus services. Persons will not be eligible for reduced fares if their sole capacity is pregnancy, obesity, and acute or chronic condition due to drugs, alcohol, or any contagious disease. All information provided will be held confidential.

A. Physical Disabilities

_____ **1. Restricted Mobility**
Disabilities requiring the use of a cane, crutches, leg braces, walker, or other orthopedic devices used to assist an individual in moving about.

_____ **2. Arthritis**
American Rheumatism Association criteria may be used for the determination of arthritic disability. Therapeutic Grade III, Functional Class III, Anatomical State III, or worse is evidence of arthritic disability.

_____ **3. Loss of Extremities**
Anatomical deformity, amputation of both hands, one hand and one foot, or loss of major function.

_____ **4. Cerebrovascular Accident**
Ongoing debilitating effect which follows an occurrence of a cerebrovascular accident.

_____ **5. Cardio-pulmonary Disease**
Serious loss of heart or lung reserves as shown by X-ray, EKG, or other tests, and in spite of medical treatment, there is breathlessness, pain or fatigue.

_____ **6. Dialysis**
Individual who must use a kidney dialysis machine in order to live.

_____ **7. Acquired Immunity Deficiency Syndrome**
AIDS/HIV positive.

B. Visual Disabilities

_____ **1. Legally Blind**
Visual impairment that is bilateral and not correctable with lenses.

_____ **2. Contraction of Visual Field**
Person whose widest diameter of an angular distance of 20 degrees, or less than 10 degrees from point of fixation, or whose visual field efficiency is 20 degrees or less.

C. Hearing Disabilities

_____ **1. Legally Deaf**
Hearing impairment that is bilateral and not correctable with a hearing aid.

D. Mental Disabilities

_____ **1. Developmentally Disabled**
Mental disability that originates before age 22.

_____ **2. Adult Mental Retardation**

_____ **3. Epilepsy**
Grand Mal or Psychomotor. People who are seizure-free for a continuous period of six months are disqualified.

_____ **4. Autism**
Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli and very inadequate social relationships.

_____ **5. Neurological Disabilities** Neurological and physical impairments not controlled by medication such as cerebral palsy or multiple sclerosis.

_____ **6. Organic Brain Syndrome/Emotionally Disturbed**
Chronic illness/disturbance that requires boarding or care home, funded work activity or workshop.

Is the disability permanent? Yes _____ No _____

If temporary, please list estimated number of months of temporary disability: _____
I hereby certify that the applicant,_____ , is disabled as defined by the preceding criteria and that the information contained on this form is true.

Does the applicant require a Personal Care Attendant (PCA) when traveling on transit vehicles? (Riders must provide their own PCA)

Never_____ Sometimes_____ Always _____

If a PCA is needed, explain why. (Personal Care Attendants are allowed to ride at no charge if assisting a passenger with verified need for a PCA)

_____

_____

_____ _____
Physician Name Date

_____ _____
Physician Signature Telephone