Des Moines Area Regional Transit Authority
620 Cherry Street
Des Moines, IA 50309
Phone 515-283-8100

Application for Half Fare

Name _____
(Print) (First) (Middle Initial) (Last)

Address _____

City_____State_____Zip _____

Date of Birth_____ Phone No._____

Email Address _____

I am applying for a DART Half Fare ID Card on the following basis. Please check only one.

- ☐ I am 65 years of age or older
- ☐ I am providing proof of a current eligibility award letter that states that I am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability*
- ☐ I am providing proof of current eligibility by the Veterans Administration as having a disability / Service Connected VA card
- ☐ I am presenting a valid Medicare Card
- ☐ I am currently a DART Paratransit rider
- ☐ I am providing a valid out of state Half Fare Id that has been approved at another transit agency
- ☐ I am medically disabled as certified by a Physician (M.D.), Psychiatrist, Psychologist (Ph.D.), Osteopathic Medicine (D.O) See Health Care Provider's Certification form on the reverse side

All applications must have valid certification prior to review and must be submitted in person with photo ID.
All replacement cards cost $5.00.

Applicant's Signature _____ Date_____

* The Social Security Award letter is not acceptable for verification unless it states that you are a recipient of disability benefits or Medicare benefits are listed.

OFFICE USE ONLY

DATE_____CARD #_____INT._____TEMP._____TO_____

Health Care Provider Certification

Must be completed and signed by one of the following licensed certified health care professional(s):
[Physician (M.D.), Psychiatrist, Psychologist (Ph.D.) or Osteopathic Medicine (D.O)]

Information on this application will remain on file with DART and is not subject to public review.

Applicants do not qualify if their sole incapacity is: pregnancy, obesity, acute or chronic alcoholism or drug addiction; and contagious diseases that pose a danger to other passengers.

The criteria for eligibility on the application are in accordance with the following definition: "A person with a disability means any individual who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, is unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected."

PHYSICIAN SECTION

I certify that according to personal examination_____
(Applicant's Name)

qualifies for the disability half fare program offered by DART. (If temporary, please specify dates.)_____

NATURE OF DISABILITY

_____ MENTAL _____ VISUAL IMPAIRMENT _____ PHYS. LIMIT_____ OTHER (PLEASE SPECIFY) _____

PHYSICIAN **PRINTED** NAME_____ DATE_____

PHYSICIAN **SIGNATURE**_____ CREDENTIALS _____

PHONE_____ADDRESS_____