



# APPLICATION INSTRUCTION SHEET - DISABILITY REDUCED FARE PROGRAM\*

申请说明页——残障人士减费票价计划\*

页面 1 (申请人须知)

\*此减费票价计划并非《美国残疾人法案》(ADA)的要求。

## 第 1 部分：申请人信息 (请仅用黑色或蓝色墨水)

1a 行：工整填写姓、名、中间名缩写 1b 行：工整填写地址 (街道、城市、州、邮政编码)

1c 行：工整填写区号和电话号码 (如无电话号码，则写“无”(NONE)) 1d 行：工整填写月、日、年。

## 第 2 部分：申请人资格\*\*

2a 行：对于此部分规定的资格，请勿填写申请表的第 4 部分，并将所需证明文件提交到 Transit Pass Office (公共交通票办公室)。

退伍军人事务部(VA)残障福利：请提交原始 VA 信件，显示被评级为 40%或更高的单一残障。

社会保障残障保险福利(SSDI)：请提交领取 SSDI 的原始信件

残障人士停车许可证：请提交 DCAB 颁发的有效许可证身份证件原件。

截肢者：无证明文件，面见目视确认。

2b 行：申请人的医疗保健专业人士(HCP)完整填写、签署第 4 部分并写明日期。

- 就此残障人士减费票价计划而言，在此所说的残障人士(Person with a Disability)不遵循 ADA 对残障人士的定义，也并非 ADA 的要求。
- 仅是身有残障并不能保证申请人有资格享受残障人士减费票价。
- 第 4b 部分说明了诊断与使用公共交通的活动能力之间的联系。
- 如果关于残障的支持证据明确证明申请人符合资格，将颁发减费票价 HOLO 卡。

\*\* 年满 65 周岁的个人：申请减费票价老年人 HOLO 卡。

\*\* 未满 65 周岁的联邦医疗保险(Medicare)持卡人：申请减费票价联邦医疗保险(Medicare) HOLO 卡。

\*\* 申请人领取 SSI 福利或符合低收入要求：申请低收入减费票价 HOLO 卡 (请电 808-768-7065 了解详情)

## 第 3 部分：用以披露医疗信息的申请人声明和授权

阅读、签名并写明日期

### 申请程序 (请仅用黑色或蓝色墨水完整填写申请表)

请亲自到 Transit Pass Office (公共交通票办公室) 提交已完整填写/签名的申请表。

地址：卡历黑公交中心(Kalihi Transit Center)——中街(Middle St)和卡美哈美哈公路(Kamehameha Hwy)两条街道转角处；电话号码：808-848-5555 (再按 5)。

办公时间：周一到周五，上午 7:30 到下午 4:00，城市假日休息 (开始排队时请不迟于下午 3:30)

仅未更改的原始、完整和经签名的申请才会得以受理。

不接受复印件、传真或数字签名。

如果申请不完整，缺少所需证明文件、身份证件、付款，或迟于 4d 方框中 HCP 所写日期起的 30 个日历日内提交，申请将不予受理。

需要出示官方有效的带照身份证件以证明身份、出生日期和\*夏威夷居民身份，如：驾照、州身份证件、护照、永久居民/外籍居民身份证件、联邦认可的印第安部落身份证件。\*证实夏威夷居住身份可通过夏威夷州身份证件或驾照。

只接受现金或信用卡付款。

带照残障人士减费票价 HOLO 卡将会发给符合条件的申请人。第 2a 部分资格有效期为签发日期起四年；第 4 部分资格有效期取决于 4d 方框中的 HCP 所写日期 (终身残障：有效期为 4 年；暂时残障：期限见 4c 行。)

如果申请人被裁定为不符合资格享受残障人士减费票价，申请人可对裁定提出上诉。

(Details on side 2 / 详情见页面 2)



# APPLICATION INSTRUCTION SHEET - DISABILITY REDUCED FARE PROGRAM\*

## 申请说明页 - 残障人士减费票价计划\*

### Side 2 (Health Care Professional Instructions & Appeal Process)

#### 页面 2 (医疗保健专业人士须知和上诉流程)

\*此减费票价计划并非《美国残疾人法案》(ADA)的要求。

#### **Section 4: Supporting Evidence of Disability by a Health Care Professional (HCP) (complete Application Form using black or blue ink only)**

第 4 部分：医疗保健专业人士(HCP)提供的有关残障的支持证据 (请仅用黑色或蓝色墨水完整填写申请表)

- The Disability Reduced Fare Program is not an ADA requirement and does not follow the ADA definition of an individual with a disability.
- Having a disability alone & completing Section 4 does not assure that the Applicant (Patient) will be eligible for the disability reduced fare program.
- HCP shall be licensed in State of Hawaii and certify disabilities only that the HCP is qualified & licensed to diagnose.
- Acceptable License Types APRN, LCSW, MD, PSY, PT, OT.

**Line 4a:** Read and Print your Patient's first and last name.

**Line 4b:** Diagnosis and Description of How the Disability Impacts Applicant's Ability to Use the Public Transit System (do not write code only).

- Specify & describe the diagnosis based on medical evidence to clearly demonstrate how the disability impacts the Patient's functional ability to use public transit without significant difficulty/reliance on the accessibility features in the city's transit system.
- Listing only symptoms (ie: weakness, leg pain) or general category of condition (ie: heart condition, mobility condition) are not acceptable.
- Non-qualifying conditions may include but are not limited to: Financial need (low income reduce fare program available-see Section 2\*\* above); temporary durations less than three (3) months; limited-English; conditions with subjective criteria or symptoms that are difficult to measure.

**Line 4c:** Indicate if the disability is Permanent or Temporary. For Temporary disabilities, indicate the expected duration in months not to exceed 24 months and not less than 3 months.

**Box 4d:** Print HCP Name, Address, Phone No., License Type & Number, License Expiration Date.

Use Agency stamp to identify Agency or Print Agency Name if no Agency stamp.

HCP signature to certify Applicant is their patient & information provided is true & correct.

Digital signatures and faxed copies are not accepted.

Date of signature.

Transit Pass Office may conduct follow-up verification of signature.

#### **申请人上诉程序**

如果申请人被裁定为不符合资格享受残障人士减费票价，申请人可对裁定提出上诉。申请人可在裁定日期起的 30 个公历日内致电 808-768-8368 或发送电子邮件至 [thebusstop@honolulu.gov](mailto:thebusstop@honolulu.gov) 联系运输服务部(DTS)，以获取如何提出上诉的说明。

裁定日期请见：未受理的申请表和退给申请人的副本中页面 1 内的“办公专用”(For official use)框



## APPLICATION FORM - DISABILITY REDUCED FARE PROGRAM\*

### 申请表 — 残障人士减费票价计划

页面 1 (由申请人完整填写, 请仅用黑色或蓝色墨水)

**\*此减费票价计划并非《美国残疾人法案》(ADA)的要求。**

公交通票办公室(Transit Pass Office) 位于卡历黑公交中心(Kalihi Transit Center) —  
中街(Middle St.)和卡美哈美哈公路(Kamehameha Hwy.) TheBus 客户服务 (808-848-5555 再按 5)

### 第 1 部分：申请人信息 (请见说明页 — 页面 1)

申请人姓名:

**1a. Applicant's Name:** \_\_\_\_\_

LAST/姓

FIRST/名

MIDDLE INITIAL/ 中间名缩写

地址:

**1b. Address:** \_\_\_\_\_

CITY/城市

STATE/州

ZIP CODE/邮政编码

电话号码:

出生日期:

**1c. Phone Number:** ( ) \_\_\_\_\_

**1d. Birth Date:** \_\_\_\_\_

MONTH, DAY, YEAR/ 月, 日, 年

### 第2部分：申请人资格 — 只勾选2a或2b部分中的一(1)个方框

申请人年满 65 周岁, 申请老年人减费票价 HOLO 卡。

申请人为未满65周岁的联邦医疗保险(Medicare)持卡人, 申请联邦医疗保险(Medicare)减费票价HOLO卡。

申请人领取SSI福利或符合低收入要求: 申请低收入减费票价HOLO卡 (请电808-768-7065了解详情)

申请人未满 65 周岁——请只勾选 2a 或 2b 部分中的一(1)个方框 (请查看说明页中的要求)

**2a.**  领取退伍军人事务部(VA)或社会保障残障保险(SSDI) 福利。

持有DCAB颁发的有效夏威夷州残障人士停车许可证。

为截肢者 (腿/脚, 臂/手)。

**2b.**  提交由医疗保健专业人士(HCP)完整填写并签名的第4部分。

- 获得减费票价的资格不遵循ADA对残障人士的定义。
- HCP认证并不保证申请人将有资格享受残障人士减费票价。

### 第 3 部分：用以披露医疗信息的申请人声明和授权

本人确认：1) HCP 在第 4 部分中对残障情况的认证并不自动保证本人有资格享受此减费票价计划；2) 虚假信息可能会造成本人的减费票价 HOLO 卡无效；3) 如果本人的申请不完整或迟于 HCP 在 4d 中所写日期起的 30 个公历日内提交, 本人的申请将会被拒。

**本人授权披露在第 4 部分中的关于本人的医疗信息。**

申请人签名

日期

父母/监护人签名 (如果申请人未满 18 岁)

关系/授权 (如非申请人)

日期

**FOR OFFICIAL USE ONLY - DO NOT WRITE IN THIS BLOCK** 办公专用——请勿在此方框中填写

Applicant Eligibility Approved.  Resident  Non-Resident Amount paid: \$ \_\_\_\_\_

Application Not Processed: Reason: \_\_\_\_\_

Notes: \_\_\_\_\_

Processing clerk: \_\_\_\_\_

Date: \_\_\_\_\_



APPLICATION FORM - DISABILITY REDUCED FARE PROGRAM\*

申请表—残障人士减费票价计划\*

Side 2 (to be completed by the Health Care Professional using black or blue ink only)

页面 2 (由医疗保健专业人士完整填写, 请仅用黑色或蓝色墨水)

\*此减费票价计划并非《美国残疾人法案》(ADA)的要求。

SECTION 4: SUPPORTING EVIDENCE OF DISABILITY BY A HEALTH CARE PROFESSIONAL (HCP) (See Instruction Sheet Side 2)

- For the purpose of this disability reduced fare program, a person with a disability does not follow the ADA definition for a person with a disability and is not an ADA requirement.
HCP shall be licensed in the State of Hawaii.
HCP shall certify disabilities only that the HCP is qualified & licensed to diagnose.
HCP shall certify disabilities based on medical evidence.
HCP certification of a disability does not assure that the Applicant will qualify for the disability reduced fare program.

4a. I certify that the Applicant (Name) \_\_\_\_\_

- is my patient,
is diagnosed with a disability which makes it significantly difficult to perform functions necessary to effectively use the city's transit system,
is reliant on the accessibility features in the city's transit system - disability impacts functional ability to use public transit service without such accommodations.

4b. Diagnosis & Description of How the Disability Impacts Applicant's Ability to Use the Public Transit System (do not write code only - see Instruction Sheet Side 2).

Blank lines for writing diagnosis and description.

4c. Permanent or Temporary: Expected duration of disability: \_\_\_\_ mos. (not less than 3 mos. & no more than 24 mos.)

4d. HCP Certification. As an HCP duly licensed in the State of Hawaii, I certify: 1) the Applicant is my Patient, 2) I completed this application with true & correct information. 3) I understand that providing false information are grounds for Licensing sanctions under HRS Chapter 436B.
Name: \_\_\_\_\_ Phone No: ( ) \_\_\_\_\_
License No & Type: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
(Acceptable Types: APRN, LCSW, MD, PSY, PT, OT)
Agency (Stamp): \_\_\_\_\_
Address: \_\_\_\_\_
City State Zip Code
Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_
\*Applications are void if submitted after 30 days of this date.

Only unaltered original, completed, and signed applications are accepted for processing. No copies, faxes, or digital signatures.