

**County of Hawai'i Mass Transportation Agency
Application Form for Hele-On Bus Disability Identification Card**

Applicant's Name _____
Last First M.I.

Mailing Address _____
P.O. Box or Street City State Zip Code

Phone No.: _____ Identification: (check one) HI Driver's License ___ HI ID ___

Other ID (Specify): _____ Date of Birth _____ Gender: ___ Male ___ Female

Terms of Usage and Release of Medical Information

I declare under penalties of penal law that the statements contained herein are to the best of my knowledge true and accurate and that I have not knowingly given a false statement or given information which I know to be false. I have read and understand the terms of the Hele-On bus Disability Identification Card (DIC) usage below and I agree to abide by them.

I also authorize my Physician to release medical information necessary to process this application. I understand that information regarding my disability will be used solely to determine my eligibility for discounted transportation services on the Hele-On Bus.

I understand that the Hele-On Bus DIC cannot be used by anyone other than me. **The Hele-On DIC must be visible to the bus operator when I board the bus and it does not allow me to ride for free.** If my Hele-On DIC is lost or stolen, it cannot be used by anyone else and I must notify the Mass Transit Agency immediately. If it is found and misused, the user will be fined. The Hele-On DIC will be valid up to two years. I must reapply to be eligible for this program, if available, prior to expiration of my DIC. Note: \$1.00 charge to replace lost or stolen Hele-On DIC's. After three (3) replacements, I must complete another application form certified by my physician.

Applicant's (or Authorized Representatives Signature):

_____ Date: _____

In order of us to evaluate your application for a Disability Identification Card, you must have your Licensed Practicing Physician certify that you are eligible for this program. Only Physicians are able to certify this form. Once the information on the reverse side of the page is completed by your Physician, the completed form must be submitted to the Mass Transit Agency for processing. If any information is missing, the form will be returned to you. You will be notified of our determination within 21 days of receiving your completed application. Your Hele-On DIC will be mailed to you (?). **In the meantime, you must pay the \$2.00 bus fare when riding the Hele-On Bus (until you receive the DIC).**

Please send the completed application form and along with a copy of your photo I.D. to:

County of Hawaii Mass Transit Agency
1266 Kamehameha Avenue, Room A-2
Hilo, Hawaii 96720
Telephone: (808) 961-8744
Fax: (808) 961-8745

