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

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TO BE COMPLETED BY A LICENSED PHYSICIAN

I, _____ certify that the above applicant qualifies for a Hele-On Bus Disability Identification Card (DIC) under one of the following categories:

___ The applicant has a physical or mental disability which clearly demonstrates that the person experiencing such disability is unable, without difficulty or assistance, to use the Hele-On bus system.

___ The applicant has an incapacity or disability which limits his/her ability to perform one or more of the following functions necessary for the effective use of the Hele-On bus system's facilities without significant difficulty (check all that apply):

___ Negotiating a flight of stairs or ramp;
___ Boarding or alighting from a Hele-On Bus;
___ Reading informational signs; or
___ Walking more than 200 feet

Description of Disability: _____

Condition is _____ Permanent _____ Temporary (State Duration) _____

A Personal Care Attendant (PCA) is required for the applicant to travel: _____Yes _____No

If YES, please list the name(s) of PCA(s):

_____

_____

Note: Only one PCA is eligible to accompany the applicant at time. PCA(s) may ride the Hele-On bus at a discounted rate of $1.00 or by using bus tickets when accompanying applicant.

Physician Please Read Carefully

I understand that per HRS 291, Part III, if I as a physician fraudulently verify that _____
Applicant's Name
is a person with a disability to enable the applicant to obtain a Hele-On Bus Identification Card, I shall be guilty of a petty misdemeanor and each fraudulent verification shall constitute a separate offense.

Physician's Name: _____, _____ _____
Last First M.I.

Mailing Address: _____ _____, _____ _____
Street/P.O. Box City State Zip Code

Date: _____ Phone: _____ Medical License No.:_____

The Mass Transit Agency will review this certification to determine the applicant's eligibility for the Hele-On Bus Disability Identification Card.

Mass Transit Agency Use Only:

Approved _____ Date _____ Denied _____ Reason _____

Card No. _____ Expiration Date: _____