County of Hawai‘i Mass Transit 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 DIC must be presented when purchasing discounted bus tickets or monthly pass and must be visible to the bus operator when I board. The DIC does not allow me to ride for free. If my 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 DIC will be valid up to two (2) years. I must reapply to be eligible for this program, if available, prior to expiration of my DIC. After three (3) replacements, I must complete another application form certified by my physician.

Applicant’s (or Authorized Representatives) Signature: __________________________

Date: ____________

In order for us to evaluate your application for a DIC, 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 upon approval within the 21 day determination period. 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 Hawai‘i Mass Transit Agency
25 Aupuni Street
Hilo, HI 96720
Telephone: (808) 961-8744
Fax:    (808) 961-8745
Email: heleonbus@hawaiicounty.gov

July 1, 2021
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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 __________________________

is a person with a disability to enable the applicant to obtain a Hele-On Bus DIC, 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 DIC.

Mass Transit Agency Use Only:

Approved _______ Date ___________ Denied _______ Reason __________________________

Card No. _______ Expiration Date: ___________