Procedure for obtaining the CCCT Reduced Limited Day Pass For People with Disabilities

1. Provide all of the information requested in Part I of the application.

2. Provide a photocopy of a proof-of-age document from the following list:

Birth Certificate	Passport
Baptismal Certificate	Armed forces discharge or separation papers
Driver's License	State Issued ID

3. If you have a Medicare Card and you are under 65 years of age you may bring or mail the application along with a clear photocopy of your Medicare Card and a clear photocopy of the proof-of-age document to the following LANTA Metro Office at 1060 Lehigh Street, Allentown, PA 18103. With a Medicare Card you are eligible for the Reduced Transit Rate of $1.00 per ride except between the hours of 7:00 am to 8:00 am and 4:30 pm to 5:30 pm when you must pay the full rate.

4. If you do not have a Medicare Card, **a Physician** must complete Part III of the application in its entirety. Once completed you may bring or mail the application along with a clear photocopy of the proof-of-age document to the LANTA Metro office.

If you qualify for the program your Reduced Limited Day Pass will be mailed to you at the address provided in Part I of the application.

LANTA does reserve the right to not process any application if the application is not properly completed or if the information provided by the applicant and/or the Physician is not legible.

If you have any questions regarding the CCCT Reduced Limited Day Pass application process please call 610-776-7433. Thank you.

Reduced Limited Day Pass Application
For People with Disabilities Card Number:

Part I - To be completed by the applicant (please type or print)

Today's Date: _____

Your Name:_____
(Last) (First) (Middle Initial)

Your Address:_____
(Number) (Street) (City) (State) (Zip Code)

Your Home Telephone Number (include the area code):_____

Your Date of Birth:_____ Male_____ Female_____

Your Signature:_____

Part II – If you have a Medicare Card send a clear photocopy of your card and a clear photocopy of proof of age document from the list in #2 on the back of this form. If you do not have a Medicare Card then Part 3 must be completed.

Part III - to be completed by a **PHYSICIAN** (please type or print)

I certify that the above named individual qualifies for a disability Reduced Limited Day Pass because: (please check as many reasons as are applicable).

_____(1). The individual cannot negotiate a flight of stairs or escalator with ease, reasonable speed and/or without aid from another individual.
_____(2) The individual cannot board or leave a transit vehicle with ease, reasonable speed and/or without aid from another individual.
_____(3) The individual cannot stand without major support in a moving vehicles operating under normal acceleration and deceleration.
_____(4) Due to uncorrectable visual impairment, the individual cannot read transit vehicle identifications or identify transit stops.
_____(5) Due to uncorrectable hearing impairment, the individual cannot hear verbal announcements or transit information through either direct personal or electronic communication.
_____(6) The individual needs (for valid medical reasons) the aid of a cane, crutches or other mechanical devices to assist in moving about.
_____(7) Due to physical or mental conditions, the individual cannot use public transit without the help of another person or special training.

The individual's disability can specifically be described as: _____

_____1. The disability is permanent (will last longer than 12 months)
_____2. The disability is temporary and can be expected to last until _____
month/day/year

Due to the disability indicated above, I hereby certify that the above named individual is unable to use mass transit facilities and services effectively as individuals who are not so affected, and to the best of my knowledge the above information is true and correct.

Physician's Signature: _____
Physician's Name:_____
Street Address:_____
City, State & Zip:_____