495 Queensbury Avenue
Queensbury, New York 12804
(518)792-1086 792-7952 fax ssggft@choiceonemail.com

GGFT Half-Fare Application

This is a medical verification form that will be used to help determine eligibility for half fare on GGFT fixed route buses. *Please note that persons 60+ years of age and those eligible for Medicare (and can present a valid Medicare card) do not need any special ID to receive half fare with GGFT.*

APPLICANT *(this section to be completed by person seeking a ½ fare card)*

_____ Date: _____
Name (please print)

_____
Mailing Address

_____
City, State, ZIP

The **APPLICANT** named above should give this form to a medical professional *(physician, physician assistant, chiropractor, optometrist, audiologist, podiatrist or clinical psychologist*) who treats or is familiar with them. That **MEDICAL PROFESSIONAL** must complete and certify below that the individual named above has a physical, mental, cognitive or visual disability that significantly limits one or more of their major life activities.

This completed form must then be returned directly to GGFT ***(by fax or mail to the address listed above)* by the MEDICAL PROFESSIONAL who signs below**. An approval letter & Half-Fare ID will then be mailed back to the **APPLICANT** by GGFT.

CERTIFYING MEDICAL PROFESSIONAL ***(to be completed by cert. med. prof.)***
I hereby certify that the APPLICANT named above has the following impairment(s) / disability(s) (check all that apply)

____ **Mobility** – significant mobility impairment (uses wheelchair, walker or other mobility aid)

____ **Physical** – significant respiratory, cardiac, dialysis, and/or neurological condition

____ **Visual -** legally blind and/or visual acuity no better than 20 /200 in best eye after correction.

____ **Mental** - mental, emotional, or cognitive impairment as outlined by the American Psychiatric Assoc. present for at least 3 months and is expected to continue.

____ **Hearing** - total deafness and/or hearing loss 70dBA or greater

____ **Special Education Student** in a NY State elementary, junior or senior high school – (certification by school on school letterhead must be attached).

CONTINUED ON BACK →

CERTIFYING MEDICAL PROFESSIONAL *(continued)*

In my professional judgment, the above named applicant has a permanent disability as described above

Please note that GGFT also operates a demand responsive para-transit service called FAME for persons with more significant levels of disability that prevents them from using a regular transit bus. FAME has its own, more detailed application process. For more information and/or a copy of that application please contact GGFT.

Med. Prof. Signature:_____ Date:_____

Name (please print):_____

Address: _____

City, State, ZIP: _____

Telephone: _____

Prof. License # _____

Relationship with applicant: _____

This completed form must be returned directly to GGFT by the medical professional signed above via fax or mail to the address listed on front

Any questions should be directed to GGFT at (518)792-1086.

Thank you.

July 26, 2016