SUNSET EMPIRE TRANSPORTATION DISTRICT

www.ridethebus.org
503-861-7433 Option #1

Sunset Empire Transportation District
Honored Citizen Application

Instructions

Sunset Empire Transportation District offers discounted fare and passes to anyone who is disabled or has a disability (temporary or permanent), is age 60 years or older or is a Veteran. To be eligible for this discount you will need to qualify for and receive an

Honored Citizen I.D. Card.

This card will have your name and photograph on the front.

Please complete the attached application to help us determine your eligibility.

Section 1: Applicant
Applicant completes this section of the application. Please note that if applicable, you will be required to provide documentation and or identification to verify your eligibility. We will make and retain a copy of this for our records. If you need this application in an alternative format please call to request one at 503-861-7433 option 1.

Section 2: Health Care Provider
You may need to ask your Health Care Provider to complete this section of the application to verify your eligibility. If you need assistance getting this application to your healthcare provider, please let us know so we can assist you.

Please return your completed application by mail or fax. You may also bring your application to the Astoria Transit Center located at 900 Marine Drive, Astoria OR. 97103.

Mailing Address:
Sunset Empire Transportation District
900 Marine Drive
Astoria, OR 97103

Fax: 503-325-1606

If you have any questions or need assistance completing this application please call our transit center staff at 503-861-7433 option 1.

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900 Marine Drive • Astoria, OR 97103 • 503-861-7433 • www.ridethebus.org

Section 1. Applicant information

Name: _____, _____
Last Name First Name

Mailing Address: _____ _____ _____ _____
Street City State Zip

Date of Birth: _____ **Telephone Number:** (_____) _____

I am applying for a Sunset Empire Transportation District Honored Citizen ID Card.
☐ This is my first ID card.
☐ This is a renewal card. My card has expired.

Certification of eligibility section (Check only one box below)

☐ **Social Security.** Attach benefit verification to this application
☐ **Senior (60+).** 60 years of age or older. Must present government issued photo ID.
☐ **Veteran.** Attach VA documentation to this application.
☐ **Currently deemed eligible for ADA Paratransit**

☐ **Health care provider certification:** To qualify under this type of eligibility, you must have the **health care provider certification** section on the reverse side completed.

I agree to release the information I am sending to Sunset Empire Transportation District for the purpose of making this application for an Honored Citizen ID card. I certify that the information I provide concerning my application is true and correct. I understand that SETD reserves the right to require additional documentation if necessary. If applying for the Honored Citizen ID card, I agree to abide by the terms of the program and photo ID card. I give my consent for SETD to take and retain a copy of my photo.

Signature of applicant _____ Date _____

FOR INTERNAL USE ONLY

_____ _____ _____
Date received **Honored Citizen Card Number** **Staff Initials**

Section 2. Health Care Provider certification section: This form is used for individuals with permanent or temporary disabilities.

Patient/applicant release:

I authorize: _____to verify my disability if requested to do so.
(Name of certified and/or licensed health care provider)

Patient/applicant signature: _____ Date:

To be completed by licensed Health Care Provider

Applicant's name: _____

Applicant's date of birth: _____

Health care provider's name: _____

Title: _____

State certification or license #: _____

Telephone number: _____

Email address: _____

Health care facility address: _____

_____

I, _____ hereby certify that I have examined the patient
(*Name of certified and/or licensed health care provider)*
listed above and it is my opinion that he/she is disabled due to illness, congenital malfunction, or other incapacity that substantially limits one or more major functions.

Disability is:

□ Permanent

□ Temporary (defined as impairment lasting not more than 12 months) Duration is _____ months.

I certify that the above is correct and that I am legally certified and/or licensed in my state as a Healthcare Provider.

Signature _____ Date_____

Transit Center staff may contact you for verification.
Completed application and health care provider certification may be mailed to the Transit Center, 900 Marine Drive, Astoria, OR 97103
503-861-7433 • www.ridethebus.org