



## Handicard Application

**Transpo** offers half-fares on its fixed route service to qualifying persons with physical or cognitive disabilities. To apply for a **Handicard** for reduced fares, please complete this application and return it to

**Transpo Handicard Program  
P. O. Box 1437  
South Bend, Indiana 46624**

It is important to complete all parts of this form; incomplete applications will be returned. All information will be kept confidential.

Please note: If you have a **Medicare** card, you may use your card as identification for reduced fares and a **Handicard** is not needed.

**Medicaid** cards are *not* valid for reduced fares.

**Please type or print.**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Initial \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Daytime phone \_\_\_\_\_ Evening phone \_\_\_\_\_

Date of birth (month-day-year) \_\_\_\_\_

Do you have a **Medicare** card?    Yes → **Enclose a photocopy of your card**    No

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### FOR OFFICE USE ONLY

Application received \_\_\_\_\_ Professional verification mailed \_\_\_\_\_ Received \_\_\_\_\_

Mobility aid \_\_\_\_\_ Determination \_\_\_\_\_

Determination mailed \_\_\_\_\_ Handicard number \_\_\_\_\_

1. What is the nature of your disability or health condition? (Be specific)

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2. Is your condition temporary?

Yes

If temporary, how long do you expect it to last? \_\_\_\_\_

No

3. Which of these mobility aids or equipment do you use to help you get where you need to go? (Check all that apply to you)

None

Powered or manual wheelchair

Powered scooter/cart

Crutches

Cane

Personal care attendant

White cane

Walker

Service dog

Route identification cards

Picture board

Other \_\_\_\_\_

To properly evaluate your request for a Handicard, it may be necessary to contact a physician or other health care professional to confirm the information you have provided. Please complete the following authorization:

Health care provider name \_\_\_\_\_

Title \_\_\_\_\_ Agency/Clinic \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Your name (print) \_\_\_\_\_

Your name (signature) \_\_\_\_\_ Date \_\_\_\_\_

**Applicant Verification**

**1. Applicant Signature**

- I certify that the information given in this application is true and correct. I understand all information will be kept confidential. I understand that for confirmation, Transpo may contact my health care professional whom I listed on the application.

Applicant signature \_\_\_\_\_

Date \_\_\_\_\_

**2. Person completing form if other than applicant (please check one):**

- I certify that the information provided in this application is true and correct based upon information given me by the applicant.
- I certify that the information provided in this application is true and correct based upon my knowledge of the applicant's health condition or disability.

Name \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_