Santee Wateree Regional Transportation Authority

(SWRTA)

HALF PASS PROGRAM ID CARD
DISABILITY APPLICATION

In order to be eligible to ride the bus at the half fare rate for individuals with disabilities, the enclosed form must be neatly filled out and the doctor's portion must be *signed and returned by a physician* certifying the existence of a debilitating disability that currently deem you as being disabled. Applications not sent by the physician will be returned upon receipt. Ask your physician's office to *mail or fax* the completed form to:

Santee Wateree Regional Transportation Authority
PO Box 2462
129 S. Harvin St
Sumter, South Carolina 29151
ATTN: Customer Service
Or
Fax: (803) 775-8986

When we receive the information a customer service representative will contact you to set up an appointment to take your photo and make the Half Pass Identification Card. You will receive the Half Pass Identification Card at that time.

Please contact us at (803) 775-9347 Ext. 147 with any questions.

Santee Wateree Regional Transportation Authority (SWRTA)

Half Fare ID Card Application

Please answer the following questions by checking the space next to either the "Yes" or "No"

1. Are you 65 years old or older? Yes____ No____
2. Do you have a Medicare Card? Yes____ No____
3. Are you a United States Veteran with a Military Photo ID Card? Yes____ No____

STOP! If you answered yes to 1, 2, or 3 above, you do not need to complete this Application. You need to show the driver proof of your status and you will ride for half fare on the SWRTA Fixed Route System.

If you answered no to the above 1, 2, and 3, please continue with the application below.

First name: _____ Last name: _____ Middle Initial: _____ ◯ male ◯ female

Address: _____

Telephone Numbers: Home: _____ Work: _____ Cell: _____

Physician to complete the information below

This is to certify that the above named individual has been/is my patient and by signing I certify the existence of a debilitating disability that currently deem this individual as being disabled. (Please state and describe disability below.) NO MEDICAL CODING

Date: _____

_____

_____

The applicant's disability is: ___ TEMPORARY (UNTIL _____/_____) month/year

___ PERMANENT

_____ _____

Physician Printed Name Physician Signature

_____ _____

Physician Phone# Physician Fax#

Completed Applications Mail To:
Santee Wateree Regional Transportation Authority
PO Box 2462
129 S. Harvin St
Sumter, South Carolina 29151
ATTN: Customer Service

SWRTA OFFICE USE ONLY

Date Received _____

Date Approved _____

Issue Date _____