



GWINNETT COUNTY TRANSIT

Half Fare Program

Persons 65 Years of Age or Older, Persons with Disabilities, or Medicare Cardholders are eligible to travel for Half Fare during all hours of operation on all Local Bus Routes.

To use the Half Fare benefit, the passenger must show proof of eligibility to the bus operator when boarding the bus. This proof of eligibility can be a GA driver's license, GA ID card, other State or federal government-issued card denoting age or disability, GCT ADA Paratransit Breeze card, or Medicare card including a MARTA Half Fare Breeze card. If an eligibility card is presented without a photograph, the bus operator may request that the passenger present an additional card with photograph as proof of identity, in order to ensure that the passenger is the authorized individual.

GCT also offers GCT Half Fare Breeze cards as a payment option. **Half Fare program passengers that transfer to and from MARTA must use the GCT Half Fare Breeze card when originating the trip on GCT and a MARTA Half Fare Breeze Card when originating the trip on MARTA to receive the free transfer.** Persons with Disabilities, who are under 65 Years of Age and are not Medicare cardholders or other disability cardholders, must obtain a GCT Half Fare Breeze card as proof of eligibility. For more information on obtaining the GCT Half Fare Breeze card, call GCT Customer Service at (770) 822-5010. Language assistance is available for persons with limited English proficiency. For persons who have difficulty using a standard phone including people who are deaf, hard of hearing, DeafBlind or speech disabled, just dial 7-1-1 to set up a Georgia Relay call with Gwinnett County Transit.

The Federal Transit Administration defines persons with disabilities as those who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are nonambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected (49 CFR 609.3).

The GCT Reduced Fare Program provides for discounted fares on GCT's local fixed route services:

- Local Fixed Routes One Way Fare: \$1.25
- Local Discount Ticketbook: \$12.50

GCT Half Fare Breeze Cards are issued at the following location:

GCT Customer Service Center

3525 Mall Boulevard, Suite 5-C
Duluth, GA 30096

Hours of Operation: Monday – Friday 6am-8pm & Saturday 7am-8pm
(770) 882-5010



GWINNETT COUNTY TRANSIT

Half Fare Program Certification Application

Last Name:	First Name:	MI:
Street Address:		Apt. No:
City:	State:	Zip:

Date of Birth			Telephone Number	
Month	Day	Year	Area Code	Phone Number

(Please check all that apply) Male: <input type="checkbox"/> Female: <input type="checkbox"/>	(Please check all that apply) Medicare Recipient: <input type="checkbox"/> 65 Years and Older: <input type="checkbox"/> Other: _____
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Customer Please Note:

- All valid Medicare cardholders, other American with Disability Act (ADA) eligibility cardholders and persons aged 65 years and older are eligible for the program. NO Medical certification is required. Provide proof of age, identity and/Medicare card with this Page to the customer service representative.
- All GCT Half Fare Breeze Card participants must resubmit an application upon expiration of the photo ID provided.
- Page 2 should be completed by the customer and license health care provider if the above information is not readily available to determine proof of disability and half fare program eligibility.

GCT Half Fare Breeze Card Affidavit

I agree to the following conditions regarding use of Reduced Fare Breeze Cards:

1. **Not Transferable:** This card is not transferable and if presented by any person other than to whom it is issued, GCT has the authority to confiscate the card.
2. **Property of GCT:** This Half Fare Breeze Card is the property of GCT, and must be presented upon use when boarding a GCT bus. Also please be advised that this card must be surrendered upon request by a GCT official.

Applicant's Release: I hereby authorize the designated Healthcare Provider to release any information necessary to complete this certification. I understand that this information is confidential and shall not be released without my approval or a court order. I understand that GCT has the right and opportunity to verify my eligibility for a GCT Half Fare Breeze Card. I understand that if any of the statements made on this application form are false or inaccurate, I will lose the privileges granted by the Half Fare Card.

Signature of Applicant: _____ **Date:** _____

This Section must be completed by an Approved Health Care Provider

1. The applicant must meet at least one of the criteria listed on the Eligibility Guidelines on Page 3.
2. The specific category number should be stated and described.
3. If a temporary (greater than 90 days, but less than permanent) qualifying condition exists, please describe the nature and expected duration.
4. The applicant's financial situation has NO bearing on eligibility.
5. The applicant's drug or alcohol rehabilitation program Does Not, in and of itself, meets program eligibility requirements.

Please select indicate the appropriate disability category from the Eligibility Guidelines on Page 3.

Category No: Brief Description: _____

Condition (Check One): Temp Perm If temporary, please specify duration: _____

Certification by an Approved Health Care Provider (Please Print)

Health Care Provider: _____

Provider Address: _____

Georgia State License No: _____

Telephone No: _____

Signature of Provider: _____ **Date:** _____

I certify that the above named individual meets the Eligibility Criteria that is listed in the guidelines GCT's Half Fare Program (Page 3). I understand that providing false information constitutes fraud and is punishable by law.

Once complete, please mail, fax (770-825-8162), or drop off pages 1 & 2 to the GCT Customer Service Center. If approved, the applicant will be sent a request in writing to visit the GCT Customer Service Center for issuance of a GCT Half Fare Breeze Card.

For Official Use Only

Approved

Denied Reason for Denial: _____

Staff Representative: _____ **Date:** _____

Medical Certification Eligibility Guidelines

Note: These guidelines are not intended to be inclusive of all disability types. However, the following categories and descriptions are provided to the health care provider as examples of generally accepted guidelines within the transit industry in interpretation of the Federal Transit Administration's (FTA) definition of disabilities for persons seeking to participate in a transit agency's half fare program.

The Federal Transit Administration defines persons with disabilities as those who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are nonambulatory wheelchair-bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected (49 CFR 609.3).

1. **NON-AMBULATORY:** An individual is unable to walk and requires the use of a wheelchair or other mobility device
2. **SEMI-AMBULATORY:** An individual has a chronic condition which substantially limits the ability to walk, or is unable to walk without the use of a caliper leg brace, walker or crutches.
3. **AMPUTATION:** An individual has an amputation of one or both hands, arms, feet or legs
4. **STROKE:** An individual has substantial functional motor deficits in any of two extremities, loss of balance and/or cognitive impairments three months post stroke.
5. **NEUROLOGICAL CONDITIONS OTHER THAN STROKE:** An individual has difficulty with coordination, communication, social interaction and/or perception from a brain, spinal or peripheral nerve injury or illness, has functional motor deficits, or suffers manifestations that significantly reduce mobility.
6. **PULMONARY OR CARDIAC CONDITIONS:** An individual has a pulmonary or cardiac condition resulting in marked limitation of physical functioning and dyspnea during activities such as climbing steps and/or walking a short distance. If diagnosis is asthma, please state whether: a) individual has been on systemic medication for the immediate past six months. OT b) individual has been required to use fast acting inhaler for three or more episodes per week for immediate past six months.
7. **VISUALLY IMPAIRED:** An individual is legally blind, whose visual acuity in the better eye, with correction, is 20/200 or less, or who has tunnel vision to 10 degrees or less from a point of fixation or so the widest diameter subtends an angle no greater than 20 degrees. An individual has low vision, and whose visual acuity is in the range of 20/70 to 20/200 with best correction.
8. **DEAF OR HARD OF HEARING:** An individual with a pure tone average greater than 70 dB in both ears, regardless of use of hearing aids.
9. **EPILEPSY:** An individual has had at least one tonic-clinic seizure with the past four months.
10. **DEVELOPMENTAL OR LEARNING DISABILITIES:** An individual has a significant learning, perceptual and/or cognitive disability. Some conditions are excluded from eligibility such as attention deficit disorder (ADD) and ADHD.
11. **MENTAL ILLNESS:** An individual whose mental illness includes a substantial disorder of thought, perception, orientation, or memory that impairs judgement and behavior.
12. **CHRONIC PROGRESSIVE DEBILITATING CONDITIONS:** An individual who experiences debilitating diseases, autoimmune deficiencies or progressive and uncontrollable malignancies. Any of which are characterized by fatigue, weakness, pain and/or changes in mental status that impair mobility.