

## ADA Half Fare and Complementary Paratransit Eligibility Criteria

ADA Half Fare means that a person has a qualifying disability under the Americans with Disabilities Act and is therefore entitled to pay one-half the regular fare on PDRTA fixed route buses. Half Fare does not apply to demand-response or paratransit service.

Complementary Paratransit means that a person with a qualifying disability cannot access the fixed route bus system for any of these reasons:

- Unable to board, ride, or disembark from an ADA accessible vehicle without the assistance of another person (except the driver/lift operator).
- Unable to ride because the route is not accessible
- The impairment prevents the person from traveling to or from a boarding/disembarking location.

Complementary Paratransit is limited to qualifying individuals who live up to 3/4 of a mile on either side of the bus route during peak travel times. Riders must reserve the trip and the fare is \$2.50. Please see our “Guide To Half Fare, ADA Service, and Complementary Paratransit Service on PDRTA’s Fixed Routes” for more information.

You will be notified in writing within 21 days if your application is approved or denied. If PDRTA denies your application, you have the right to appeal. Information how to appeal will be included with the denial letter.



## **APPLICATION FOR ADA Half Fare or COMPLEMENTARY PARATRANSIT**

Pee Dee Regional Transportation Authority  
Post Office Box 2071, 313 Stadium Rd  
Florence, SC 20503  
(843) 629-2060  
TDD- (843) 664-5715  
Visit our web site:  
[www.pdrta.org](http://www.pdrta.org)

**PLEASE READ THE BACK OF THIS PUBLICATION BEFORE COMPLETING**

Please check one of the following:

ADA Half Fare Card

Complementary Paratransit Card

1. Read Instructions on Back of Brochure
2. Complete Section 1 of this form
3. Have your health care professional complete Section 2 of this form.
4. Mail your application to:  
PDRTA  
Post Office Box 2071  
Florence, SC 29503

**Section 1—Applicant Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Under penalty of applicable law, I declare that the information provided is true and correct:

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**PDRTA USE ONLY**

Date Rec'd: \_\_\_\_\_

Date Approved: \_\_\_\_\_ Denied: \_\_\_\_\_

Date Card Mailed: \_\_\_\_\_

**Section 2—Physician's Statement**

**Special Note:**

This portion of the application must be completed by a Health Care Professional and must indicate the type of supporting device used by the applicant, if any.

**Please read back of brochure for eligibility criteria.**

The person below qualifies for

ADA Half Fare Card  Complementary Paratransit

This is to certify that \_\_\_\_\_  
Name of Applicant

has a physical disability of \_\_\_\_\_  
Type of Disability

and is required to use the following or has a walking impairment as indicated:  wheelchair/scooter  braces  
 walker/cane  crutches  service animal  
 portable respirator  impairment in mobility

A Personal Care Attendant is necessary during transit:  
 Yes  No

This disability is  Permanent  Temporary

If temporary, state the length of time: \_\_\_\_\_

Signature of Health Care Professional \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Health Care Professional \_\_\_\_\_

Address of above \_\_\_\_\_ Phone # \_\_\_\_\_