FLASH [FunLeisure Access Savings and Health] Card

Application for a discount card for Seattle/King County residents age 18-59 with disabilities

Age Friendly Seattle • P.O. Box 34215 • Seattle, WA 98124-4215

FLASH Card holders must be residents of Seattle or King County, age 18 - 59, with qualifying disabilities, as defined in the Eligibility Criteria for the Regional Reduced Fare Permit for public transportation (see http://metro.kingcounty.gov/tops/accessible/pdf/RRFP-info.pdf)

Complete this form and provide a copy of one (1) the following. Check ONLY ONE (1):

- ❑ A current Metro ADA Paratransit Card
- ❑ Permanent reduced fare permit for disabled persons (only ages 18 - 59), back & front (**NOTE: If age 60+, apply for a Gold Card for Healthy Aging, which provides similar benefits.**)
- ❑ Regional Reduced Fare Permit Certification of Eligibility, signed by approved health care provider
- ❑ FLASH Card Certification of Eligibility, signed by approved health care provider (**see reverse**)
- ❑ Award letter or letter of verification (no more than 12 months old) of Social Security Disability Income (SSDI), Supplemental Security Income (SSI); Veterans Administration Income or General Assistance Unemployable (GAU/GAX).

Please Print

Name _____
First Middle Last

Address _____
Street City State Zip

Date of Birth _____ Phone No. _____
Area Code

ONLY if none of the documents above are available, complete the following. Check ONLY ONE (1):

- ❑ I am providing proof of eligibility and am receiving Social Security Disability Benefits or Supplemental Security Income Benefits due to disability.
- ❑ I am providing proof of current eligibility by the Veterans Administration as having a disability of at least 40%.
- ❑ I am presenting a valid Medicare card issued by the Social Security Administration.
- ❑ I am providing a valid Regional ADA paratransit card, issued by _____(Agency). This ADA paratransit card expires _____.
- ❑ I am providing a valid ADA paratransit card from outside the region.
- ❑ I have one or more obvious physical impairments.
- ❑ I am currently participating in a vocational career program with the Washington State Individual Educational Program(IEP).
- ❑ I have a medical disability as certified by a Physician, Psychiatrist, Psychologist (Ph.D.) Physician's Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.) or Audiologist, licensed in the State of Washington. **See p. 2 of this application.**

Send this form with proof of eligibility, to Attn: **Age Friendly Seattle**:

By mail:	Aging and Disability Services P.O. Box 34215 Seattle, WA 98124-4215	By e-mail: AgeFriendly@seattle.gov	By fax: (206) 684-0689

Certification of Eligibility

Applicant's Release

I hereby authorize the physician 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 Age Friendly Seattle shall have the right and opportunity to verify my eligibility for a FLASH 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 FLASH Card and may be subject to criminal prosecution in accordance with Washington State Law for theft (RCW #9A.56.020).

Applicant's Signature _____ Date _____

This section to be completed by an approved Health Care Provider

Signatures of Health Care Providers other than those below are not acceptable:

Washington State-licensed:

- Physician (M.D. or N.D.)
- Audiologist certified by the American Speech, Language and Hearing Association
- Psychiatrist (M.D.)
- Physician's Assistant (P.A.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)

Instructions:

1. This applicant must meet at least one of the criteria and conditions listed in King County Metro Transit's Medical Eligibility Criteria and Conditions brochure (see http://metro.kingcounty.gov/tops/accessible/pdf/RRFP-info.pdf)
2. The specific Medical Eligibility Criteria number must be noted in the space provided.
3. If Section 6.4 is used, this person must be diagnosed by you as being "Acute-at-risk." The appropriate subsection (a, b, c or d) must be included along with the name and phone number of the work activity center, training or rehabilitation program in which this patient is currently a patient. Note: An applicant's enrollment in a drug or alcohol rehabilitation program does not, in and of itself, meet eligibility requirement.
4. An applicant's financial situation has no bearing on eligibility.

To be completely filled out by the approved Health Care Provider:

I certify that _____ meets the Medical Eligibility Criteria _____
(Applicant) SECTION & SUBSECTION Number

If Section 6.4, (a, b, c or d) enter name of qualifying program: _____

Please check the appropriate boxes:

- ❑ Yes ❑ No The disability is Temporary. Specify length of disability:_____months. A temporary disability must be expected to last at least three months, but no longer than one year.
- ❑ Yes ❑ No The disability is Permanent.
- ❑ Yes ❑ No This applicant requires a Personal Care Attendant (if yes: ❑ temporary ❑ permanent)

Verification of Approved Health Care Provider

Please Print

Name _____ Phone No._____

Provider or Agency Address _____

Washington State License No. _____

I understand that if any of the statements made on this application form are false or inaccurate, I will be subject to criminal prosecution in accordance with Washington State Law for theft (RCW #9A.56.020).

Signature _____ Date _____