C&J

Half-Fare Program

Effective: July 2007
Revised: December 2018

Individuals who qualify for C&J's Half-Fare Program are entitled to ride our regular fixed route coaches for one-half the regular adult full fare during off-peak times. Daily off-peak times are defined daily as; **Northbound** routes originating from South Station: 7:00 a.m. – 10:00 a.m., and **southbound** routes originating from Dover: 5:30 p.m. – 10:30 p.m. This program does not apply to C&J's direct New York service.

Who is eligible?
The Half-Fare Program is available for those individuals who are 65 years of age or older, for individuals who are Medicare recipients, or for those who have a physical or mental disability that is verified by a licensed physician.

How do I qualify?
1. Persons 65 years of age or older are not required to fill out the application. A regular picture ID validating age is required at the time of purchase to receive half-fare privileges.
2. Medicare card holders and individuals with disabilities must fill out the Half-Fare Program application and need to be in possession of a ½ Fare Card issued by C&J prior to traveling.
    A. Medicare cardholders must complete and sign part I of the application form.
    B. Persons with disabilities who are not 65 years of age or older and who do not have a Medicare card must complete and sign Part I and must also have a licensed physician fill out and sign Part II.

Instructions on obtaining a ½ Fare Card:
Bring the completed and signed application form and one other supporting document to include a photo ID, a driver's license, State ID, or birth certificate to one of our locations in Dover, Portsmouth or Newburyport 24-Hours daily. Forms are available online or at our agencies in Dover, Portsmouth and Newburyport.

The applications will be reviewed at the Portsmouth Transportation Center and cards will be issued via mail or in-person upon acceptance into the program. Individuals must submit the completed application form and be approved before a ½ Fare Card will be issued and before persons are eligible for half-fare rates.

Please note: The ½ Fare ID card is required and must be shown when purchasing a ticket to receive half-fare privileges.

Card replacement
There is no charge for the original ID card. If your card is lost or stolen, please notify C&J immediately by calling 800-258-7111. Replacement IDs will be issued at a cost of $2.00 per card. Cards are non-transferable. Cards used improperly will be confiscated and privileges will be revoked.

If there are any questions about the Half-Fare Program, please call 800-258-7111 daily.

C&J
HALF-FARE PROGRAM
APPLICATION FORM - PART I

Name: _____
Last First Middle Initial

Address:_____
Street City Zip

Phone : (_____)_____ Soc. Sec. : _____ -- _____ -- _____

Date of Birth: _____

I am applying for a Half-Fare Program I.D. card because:

Check One

A. I have a Medicare Card ☐
Must present Medicare card

B. I have a legally-documented disability ☐
A physician must complete Part 2 of the application

I certify that the information provided is true and agree to release this information to C&J for the purpose of obtaining Half-Fare Program Card. I understand the card is for my personal use and is not transferable to any other person. I grant C&J permission to verify the information given on Parts 1 and/or 2 of this form.

_____ _____
Signature of Applicant Date

C&J
HALF-FARE PROGRAM
APPLICATION FORM - PART II

(to be completed by a physician only)

To be eligible for the C&J Half-Fare Program, your patient/client must have a physical or mental condition that falls within the medical criteria listed below. If you confirm that the patient/client is physically or developmentally disabled, that person will be eligible for reduced fares on C&J public bus services. Persons will not be eligible for reduced fares if their sole incapacity is pregnancy, obesity, acute or chronic condition due to drugs, alcohol, or any contagious disease. All information will be held confidential.

Please circle the number which applies to the applicant's condition:

Physical Disabilities

1. Restricted Mobility: Disabilities requiring the use of a cane, crutches, leg braces, walker, or other orthopedic devices used to assist an individual in moving about
2. Arthritis: The American Rheumatism Association criteria may be used for the determination of arthritic disability. Therapeutic Grade III, Functional Class III, Anatomical State III, or worse are evidences of arthritic disability.
3. Loss of Extremities: Anatomical deformity, amputation of both hands, one hand and one foot, or loss of major function
4. Cerebrovascular Accident: Ongoing debilitating effect which follows on occurrence of a cerebrovascular accident
5. Cardio-pulmonary Disease: Serious loss of heart or lung reserves as shown by X-ray, EKG, or other tests, and in spite of medical treatment, there is breathlessness, pain or fatigue
6. Dialysis: The use of a kidney dialysis machine in order to live
7. Acquired Immunity Deficiency Syndrome: AIDS/HIV positive

Visual Disabilities

8. Legally Blind: Visual impairment that is bilateral and not correctable with lenses
9. Contraction of Visual Field: Widest diameter of an angular distance of 20 degrees, or less than 10 degrees from point of fixation, or a visual field efficiency is 20 degrees or less

Hearing Disabilities

10. Legally Deaf: Hearing impairment that is bilateral and not correctable with a hearing aid

Mental Disabilities

11. Developmentally Disabled: A mental disability that originates before age twenty-two
12. Adult Intellectual Disability
13. Epilepsy (grand mal or psychomotor): Anyone who is seizure-free for a continuous period of six months is disqualified

14. Autism: Monotonously repetitive motor behavior, severe withdrawal, inappropriate response to stimuli, and very inadequate social skills
15. Neurological Disabilities: Neurological and physical impairments not controlled by medication (such as cerebral palsy or multiple sclerosis)
16. Organic Brain Syndrome or Emotionally Disturbed: A chronic illness or disturbance that requires boarding or home care or a funded work activity or workshop
17. Other_____
    _____
    _____

Is disability permanent? Yes ☐ No ☐
(If temporary, please indicate the month/year temporary disability ends: _____)

I hereby certify that the applicant, _____, is disabled as defined by the preceding criteria and that the information contained on this form is true.

Physician's Name: _____
(please print)

Physician's Signature: _____

Date: _____ Telephone No.: _____