



APPLICATION FOR REDUCED FARE CARD

FOR OFFICE USE ONLY

Date Issued

Expiration Date

Anyone who presents a valid Medicare card is entitled to reduced bus fares. If you are at least 65 years old or you are disabled and you do not have a Medicare card, you may qualify for a Metro Ride reduced fare card. To apply for a card, just complete the application below and submit it to Metro Ride. Please note that a physician or qualified agency must complete Part 2.

Part 1 (to be filled out by the applicant - please print)

Name: (Last, First, Middle Initial) _____ Phone: _____

Address: (Street, City, State, Zip) _____

Phone: _____ Date of Birth: _____

How long have you been disabled? _____

- Has the Social Security Administration determined that you are eligible for disability benefits?
 Yes No *(if yes, attach a copy of the letter you received from the Social Security Administration)*
- Do you currently have a valid Medicare card issued by the Social Security Administration?
 Yes No

I hereby Authorize (Physician or Qualified Agency Name) _____ to release information to Metro Ride concerning by disability.

Applicant Signature: _____ Date: _____

Part 2 (To be filled out by physician or qualified agency)

Applicant Name _____ is unable to perform the following function(s) necessary for the effective use of mass transportation facilities without significant difficulty.

(Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Board or alight from a standard bus | <input type="checkbox"/> Count/manipulate change |
| <input type="checkbox"/> Stand in a moving bus | <input type="checkbox"/> Identify stops |
| <input type="checkbox"/> Read information signs | <input type="checkbox"/> Remember to get on/off at the correct stop |
| <input type="checkbox"/> Hear and/or understand announcements by driver | <input type="checkbox"/> Signal stop |
| <input type="checkbox"/> Communicate to Metro Ride employees | |

What diagnosis makes these functions significantly difficult for the applicant?

This limitation is: (check one) Temporary until _____ Permanent

Print Name & Title of Physician or Qualified Agency Representative _____ Phone _____

Signature of Physician or Qualified Agency Representative _____ Date _____