Reduced Fare Program Application

Information & Eligibility:

The Federal Transit Administration requires agencies receiving federal funding to offer a fixed route Half Fare program to seniors, people with disabilities and individuals with Medicare cards. People with disabilities for this purpose are defined by FTA as;

> *"those individuals who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, including those who are non-ambulatory 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."*

Having a disability does not necessarily qualify an individual for a reduced fare. Income is not a determining factor. NAIPTA defines senior citizens as those individuals age 60 and over. Exclusions to the Reduced Fare eligibility include: pregnancy, obesity, acute or chronic alcoholism or drug addiction, contagious diseases and temporary disabilities with a duration of less that 90 days.

Reduced fare cards are valid for 90 days and up to 3 years. Any fees charged for the completion of Certification Forms are not the responsibility of NAIPTA. In addition, NAIPTA reserves the right to verify certification forms.

Applicant Instructions

1. Complete the Reduced Fare Application. (Answer all questions. Disability alone does not qualify a person for a reduced fare. Ability to pay a fare is not determining factor.)
2. Submit to the Customer Service office at NAIPTA, 3773 N. Kaspar Dr, Flagstaff, AZ 86004
3. If you are a senior citizen age 60 or over, have a current Medicare card or are a veteran with a VA service related disability rating of 100%, complete the first page of this application. Bring identification with proof of age, Medicare card or VA documentation rating to the Customer Service office at NAIPTA, 3773 N. Kaspar Dr, Flagstaff, AZ 86004.
4. Once a completed application has been received, we will notify you by mail. You may also check the status of your application by calling (928) 779-6624. Incomplete applications will be returned to applicant for completion before review.

Physician Instructions

1. Complete all questions in section marked "Physician Certification". **Please do not leave items blank.** Disability alone does not qualify a person for a reduced fare. Ability to pay a fare is not a determining factor.
2. Submit Physician certification form directly to NAIPTA, or else send with client in a **sealed** envelope from physician's office.

NAIPTA
Reduced Fare Program
3773 N. Kaspar Dr.
Flagstaff, AZ 86004

Fax: (928) 779-6868
Phone: (928) 779-6624

e-mail: transportation@naipta.az.gov

This form is available in alternate formats upon request.

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APPLICANT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Male:____ Female:___ Date of Birth:_____(mm/dd/yyyy)

Home Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Phone: work_____ cell_____ other_____

E-mail address:_____

QUALIFYING INFORMATION

To be eligible for a NAIPTA Reduce fare you must meet one or more of the eligibility conditions below. Check all that apply.

☐ **Senior:** (Age 60 and over) Bring photo ID and proof of age to the customer service office.

☐ **Medicare Recipient:** Bring photo ID and copy of Medicare card to customer service office.

☐ **Veteran with Disability:** Bring documentation of Veterans Administration (VA) service-related disability rating of 100% to the customer service office.

☐ **Certified by another transit agency:** (Temporary card only)
Agency Name:_____ Expiration Date:_____
City and State of issue:_____

☐ **Mountain Lift Eligible:** Expiration Date:_____

☐ **Person with a Disability:** Eligible disabilities are defined as being unable, *without special facilities or special planning or design, to utilize public transportation facilities and services as effectively as persons who are not so affected.*

1. Specify disability:_____
2. Explain how your condition affects your ability to use public transportation:

_____

_____

3. Have your doctor complete the Physician Certification and return to NAIPTA. **Must be dated within past 30 days.**

I understand that information provided is for the purpose of determining eligibility and all information will be kept confidential. I have read and understand all reduced fare program information and affirm that the information provided is true and complete. I understand that fraud or abuse will result in confiscation of the card and termination of my eligibility.
Signature:_____ **Date:**_____

Circle one:	**Official Use Only**	**ID CARD**
Eligible	Date:_____	Issued by:_____
Temporary	Reviewed by:_____	Date:_____
Ineligible	reason for ineligibility:_____	Expiration date of card:_____
		Logged in Database:_____

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PATIENT/APPLICANT RELEASE

I authorize Dr._____ to complete this application and verify my disability, to Northern Arizona Intergovernmental Public Transportation Authority.

Name:_____

Date:_____Birthdate:_____

Applicant Signature:_____

PHYSICIAN CERTIFICATION

Physician Name:_____

Physician License #:_____

Phone #:_____

Address:_____

***Complete all 7 questions below.**
***From criteria at right, indicate disabling condition.**
***Check all that apply.**

1) Is the applicant able to perform Activities of Daily Living (ADL's)?
If no, explain:

_____

_____

2) Does disability affect the person's ability to ride the bus?
Explain. Include what special facilities, planning, or design are required:

_____

_____

3) Does the condition involve a contagious disease or does the individual pose a danger to others?

_____

_____

4) Is condition controlled by medication? Yes____No____
5) Is condition permanent? Yes_____ No_____
If "no", give duration of condition_____ months
6) Is a Personal Care Attendant (PCA) required?
Always_____ Sometimes_____ Never_____
Explain why special assistance is needed:

_____

_____

7) Do you require the use of a service animal? Y___ N___
Type of animal _____
What service does your animal provide?

_____

I certify that I have examined the patient listed above, that I am legally licensed under the laws to practice medicine; and completed this form to the best of my ability.

Signature of Doctor Date

ELIGIBILITY CRITERIA

Section A

Non-Ambulatory Disabilities

_____ Impairments which require the individual to use a wheelchair.

Semi-Ambulatory and Physical Disabilities

_____***Restricted mobility***: Requires the permanent use of a walker, cane, crutches, long leg brace or other orthopedic appliance.
List type of mobility aid:_____

_____***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.

_____***Dialysis***: Individual who must use a kidney dialysis machine in order to live.

_____***Loss of Extremities*** (both hands/one hand and one foot/both feet) Please specify:_____

_____***Other***: Please specify:_____

Hearing or Visual Disabilities

_____***Legally deaf:*** Hearing impairment that is bilateral and not correctable with hearing aid.

_____***Legally blind***: Visual impairment that is bilateral and not correctable with lenses.

_____***Contraction of visual field:*** Persons whose widest diameter of visual field subtends angular distance of 20 degrees or less than 10 degrees from point of fixation; or visual field of efficiency is 2- degrees or less.

Section B : Complete all sections.

Cognitive or Mental Disabilities:

1. From Diagnostic and Statistical Manual of Mental Disorders (DMS):
   List code number:_____
   Specify name of disorder:_____

2. Check category:

_____***Developmental Disabilities***: Persons with a disability due to intellectual disability, autism, or other related condition that originated before age 22.

_____***Adult Cognitive Impairment:*** Persons whom by reason of traumatic brain injury or illness occurring after age 18.

_____***Epilepsy:*** Grand mal or Psychomotor. Persons who are seizure-free for a continuous period of six months are disqualified.
List date of last seizure:_____(mandatory)

_____***Neurological Disabilities:*** Neurological and physical impairments not controlled by medication (i.e., cerebral palsy or multiple sclerosis).

_____***Chronic Mental Illness:*** Persons with long-term or severe mental health symptoms including schizophrenia, organic brain syndrome and bipolar disorder that affect activities of daily living (ADL's).

3. **Applicant must also meet one of the following conditions:**

_____Living in an assisted living home environment.
Name of Facility:_____

_____Living at home or under supervision with support services, public guardianship or other appointed guardianship.
Name of Guardian_____

_____Actively participating in a training or rehabilitation program or therapy established under federal, state or local government agencies
Name of Program_____
Phone:_____

Return form to: NAIPTA Reduced Fare Application Program,
3773 N. Kaspar Dr, Flagstaff, AZ 86004 or Fax 928-779-6868
or scan/e-mail to transportation@naipta.az.gov.
Must be in a sealed envelope if given to patient to hand carry.

(updated 3.12.2013)