Mountain Line

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 Medicare recipients. For this purpose, people with disabilities are defined by the FTA as:

*“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. Mountain Line defines senior citizens as individuals who are 60 years of age and over. Exclusions to Reduced Fare eligibility include: pregnancy, obesity, acute or chronic alcoholism or drug addiction, contagious diseases, and temporary disabilities with a duration of less than 90 days.

Reduced Fare photo ID 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 Mountain Line. In addition, Mountain Line 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. Income or ability to pay fare is NOT a determining factor.)
2. Submit application to: Mountain Line, Reduced Fare Program, 3773 N. Kaspar Dr., Flagstaff, AZ 86004.
3. If you are a senior citizen (60 years of age or over), a Medicare recipient (not Medicaid), a SSDI recipient, or a disabled veteran with a VA service-related disability rating of 100%, complete the first page of this application. Provide verifying documentation to: Mountain Line, Reduced Fare Program, 3773 N. Kaspar Dr., Flagstaff, AZ 86004.
4. Once a completed application has been received, we will notify you of the eligibility determination via phone. You may also check the status of your application by calling (928) 679-8911. Incomplete applications will be returned to the applicant for completion before review.

# Professional verification Instructions

1. Healthcare provider must complete all questions of the Professional Verification (page 3). **Please do not leave items blank.**
2. Submit Professional Verification form directly to Mountain Line or send with the applicant in a **sealed** envelope.

Mountain Line Reduced Fare Program 3773 N. Kaspar Dr.

Flagstaff, AZ 86004

Fax: (928) 779-6868

phone: (928) 679-8911

 email: eligibility@mountainline.az.gov

This form is available in alternate formats upon request.

 **Mountain Line Reduced Fare Program Application**

#

# APPLICANT INFORMATION

First Name: Last Name: Middle Initial: \_\_\_\_\_\_\_\_

Male: \_\_\_\_\_Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# QUALIFYING INFORMATION

To be eligible for the Mountain Line Reduced Fare Program you must meet one or more of the eligibility conditions below. Check all that apply.

**Senior** (Age 60 and over): Provide photo ID as proof of age.

**Medicare Recipient:** Provide photo ID and a copy of current Medicare card.

 **Social Security Disability Insurance (SSDI) Recipient:** Provide a copy of Social Security Benefit

 Verification Letter.

**Veteran with Disability:** Provide documentation of Veterans Administration (VA) service-related disability rating of 100%.

**Certified by another transit agency:** (Temporary card only)

Agency Name: Expiration Date:

City and State of issue:

**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 healthcare provider complete the professional verification form and return to the Mountain Line office. (**Must be dated within 30 days)**

I understand that the 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: Mountain Line office Use Only ID CARD

Eligible

Date:

Issued by:

Temporary Reviewed by: Ineligible Reason for ineligibility:

Date: ­ Expiration date: Logged in Database:

**Mountain Line Reduced Fare Program Application**

**Professional Verification**

**Authorization for Release of Information**

I authorize to complete this professional verification of my disability for the purpose of determining eligibility for the Mountain Line Reduced Fare Program

Applicant name:

Date: Birthdate: Applicant Signature:

**Professional Information**

Name: License type: Number: 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? Yes No

If no, explain:

**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 despite medical treatment, there is breathlessness, pain, or fatigue.

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

 ***Loss of Extremities***

Please specify: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other

 **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.

1. Does disability affect the person’s ability to ride the bus? Yes No If yes, explain (Include what special facilities, planning, or design are required):

**Section B: Complete all sections (1-3)**

**Cognitive or Mental Disabilities**

**1.** Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis code and name of disorder:

1. Does the condition involve a contagious disease or does the individual pose a danger to others? Yes No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the condition controlled by medication? Yes No
2. Is condition permanent? Yes No

If “no”, give duration of condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is a Personal Care Attendant (PCA) required?

Always Sometimes Never

**2.** Check category:

\_\_\_\_***Developmental Disabilities:***  Persons with a disability that began before the age of 22 (ex: cognitive disability, autism, or other)

\_\_\_\_***Adult Cognitive Impairment:*** Persons 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 not eligible. List date of last seizure: (mandatory)

\_\_\_\_***Neurological Disabilities:*** Neurological and physical impairments not controlled by medication (ex: cerebral palsy, multiple sclerosis, or other).

Explain why special assistance is needed:

1. Does applicant require the use of a service animal?Yes No Type of animal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What service does the animal provide?

I certify that I am legally licensed to practice as indicated herein; I have evaluated the applicant listed above; and I have completed this professional verification form to the best of my ability.

**Signature of Professional:**

 Date:

\_\_\_\_***Chronic Mental Illness:*** Persons with long-term or severe mental health symptoms affecting ability to perform activities of daily living (ex: schizophrenia, organic brain syndrome, bipolar disorder, or other).

1. **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 via:**

**Mail**: Mountain Line, 3773 N. Kaspar Dr, Flagstaff, AZ 86004

**Fax:** 928-779-6868; **Email:** eligibility@mountainline.az.gov