Mountain Line
Reduced Fare Program Application

Mountain Line offers the option for qualifying individuals to pay a discounted rate of half the regular fare on the fixed route bus system. This includes youth (age 7 – 17); seniors (age 60 and older); Medicare card holders; Veterans; Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) recipients; and riders with a disability. Riders must show valid proof of eligibility to qualify for reduced fare. Acceptable IDs include a K – 12 school photo ID (current school year), a driver's license or other government issued photo ID as proof of age; Medicare Card accompanied by a government issued photo ID; or a Mountain Line issued Reduced Fare Program photo ID.

To apply for eligibility for the Reduced Fare Program, complete and submit the application with supporting documentation via:

Mail:
Mountain Line
Reduced Fare Program
3773 N. Kaspar Drive
Flagstaff, AZ 86004

In-person: Mountain Line customer service desk
(Hours: M – F, 8 am – 5 pm, closed noon – 1 pm)
or
Fax: (928) 779-6868

Once a completed application is received and reviewed, we will notify you of the eligibility determination via phone. All questions must be answered and supporting documentation must be provided. Incomplete applications will be returned to the applicant for completion before review. Any fees charged for the completion of the application are not the responsibility of Mountain Line. Mountain Line reserves the right to verify supporting documentation.

The Mountain Line Reduced Fare Program photo ID is issued to approved riders at the Mountain Line office. It is re-loadable with a 30-day bus pass or stored value. It can also be used as proof of eligibility when paying cash fare for each one-way trip or day pass. There is a $3 replacement fee for a Reduced Fare Program photo ID card that has not expired. The Reduced Fare Program photo ID is valid through the expiration date printed on the card. It is the responsibility of the participant to re-apply for the Reduced Fare Program as needed to determine if you continue to qualify.

If you have additional questions, need assistance, or to request this form in alternate formats, please contact Mountain Line staff via:
Phone: (928) 679-8911 or
Email: eligibility@mountainline.az.gov

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.

- ☐ **Youth** (age 7 – 17): Provide K - 12 school photo ID (current school year) or government issued photo ID as proof of age
- ☐ **Senior** (age 60 and over): Provide government issued photo ID as proof of age
- ☐ **Veteran:** Provide government issued photo ID and certificate of discharge (DD214) as proof of military service; or proof of eligibility for VA disability benefits
- ☐ **Medicare Recipient:** Provide government issued photo ID and a copy of Medicare card
- ☐ **Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) Recipient:** Provide government issued photo ID and a copy of Social Security Benefit Verification Letter
- ☐ **Person with a Disability:** Completion of the professional verification form is required (page 3)

  Please sign the Authorization for Release of Information section of the professional verification form. Provide the form to a healthcare provider to complete and submit (must be dated within 30 days).
- ☐ **Certified by another transit agency:** (Temporary card only)

  Agency Name/City/State:_____Expiration Date:_____

I understand that the information provided in this application is for the purpose of determining eligibility for the Mountain Line Reduced Fare Program. All information will be kept confidential. I have read and understand all the information about the Reduced Fare Program. I 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: _____	Date: _____
Ineligible	Reason for ineligibility:_____	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: _____

Address:_____

Phone:_____

Indicate the disabling condition in the right column and check all below that apply

1) Is the applicant able to perform Activities of Daily Living?
Yes_____No _____
If no, explain:

2) Does the individual pose a danger to others?
Yes _____No _____
If yes, explain:

3) Does the condition involve a contagious disease?
Yes _____ No _____

4) Is the condition controlled by medication?
Yes _____ No _____

5) Is condition permanent? Yes _____ No _____
If no, give duration of condition: _____

6) Is a Personal Care Attendant (PCA) required?
Always _____ Sometimes _____ Never _____
If so, explain what special assistance is needed:

7) Does the 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: _____

ELIGIBILITY CRITERIA

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 a 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.

Cognitive or Mental Disabilities (complete 1-3)

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

_____

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).

____***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).

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 via:
Mail: Mountain Line, 3773 N. Kaspar Dr., Flagstaff, AZ 86004
Fax: 928-779-6868