



Disability and Discount Eligibility Form

This application, when completed, will entitle the customer to discounted fares when traveling on CARTS. Certification of a disability by a physician or qualified medical professional is required. The information requested in this application is confidential.

I hereby make application and agree to abide by the provisions for the discounted fares. In making this application, I agree to release information requested on this form to CARTS for the purpose of discounted fare eligibility and verification of disability.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #1: _____ Phone #2: _____ Date of Birth: _____

Signature: _____

Disability:

(Must be completed by a qualified medical professional)

Please check the appropriate box:

Non-ambulatory

Visual

Medicaid

Semi-ambulatory

Hearing

Other _____

MHMR

Medicare

Disability Verification:

I verify that the applicant has a disability, which is, permanent or temporary (if temporary, please provide effective dates: _____ to _____). The qualified applicant has or is regarded as having a disability that substantially limits one or more major life activities such as caring for himself/herself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning or working (ADA Definition).

I understand that the applicant is eligible for discounted fares when using CARTS, based on my professional verification of the applicant's disability.

Doctor Name: _____

Signature: _____

Clinic/Agency: _____ Doctor ID#: _____

Office Phone: _____ Date: _____

**For CARTS
Use Only**

Authorized by: _____ Date: _____

Customer Notified Date: _____