



Application for Eligibility DISABLED RIDER PASS

This card will allow you to ride on demand/curb to curb buses at a reduced fare and fixed routes for no fare. All buses are mobility device accessible.

This certification form will be used to determine eligibility. Please complete this form in its entirety. A Physician or other Approved Certifying Agency must complete Section 4.

Once you have completed this form, call 469-474-2435 to schedule your in person assessment. If approved, a photo will be taken for the STAR Transit Reduced Fare ID card. There will be a \$2.00 processing fee. This Reduced Fare ID card must be presented to the driver each time you board one of these services. Recertification will be required. Cards expire 12/31, three years after the date of issuance. You'll need to follow the same process above.

SECTION 1

Name (Last, First, Middle Initial): _____

Street Address: _____

City, State, Zip: _____

Phone #: _____

Date of Birth: _____ Male Female

Emergency Contact: _____ Number: _____

Can you get to a fixed bus route bus stop? Yes No

SECTION 2

Do you have a disability? Yes No

Is this a temporary condition? Yes No

If yes, length of time. _____ Months _____ Weeks

Do you use any of the following mobility aids? (Check all that apply)

Cane		Leg Braces		Power Scooter	
Communication Board		Manual Chair		Walker	
Crutches		Picture/Alphabet Board		White Cane	
Guide Dog		Portable Oxygen Supply		Other	
Large Power Chair		Power Chair			

SECTION 3

Applicant Signature: _____ **Date:** _____

If application is being completed by someone other than the applicant, please complete the line below.

Name: _____ **Relationship:** _____ **Phone #:** _____

SECTION 4 - CERTIFICATION (COMPLETED BY PHYSICIAN OR OTHER APPROVED CERTIFYING AGENCY)

As indicated by my signature below, I confirm the information contained in Section 2 is true and correct and in my professional opinion qualifies the person requesting eligibility for the disabled fare.

Verifying Examiner Name (Print): _____

Examiner Title: _____

Phone Number: _____

Verifying Examiner Signature: _____

Comments: _____

FOR STAR TRANSIT OFFICE USE ONLY

Authorized by: _____ **Date:** _____

Approved

_____ **Unconditionally Eligible**

_____ **Temporary** _____ **Length of time**

Denied

Comments: _____

For more information or to ask questions, contact:
STAR Transit Mobility Management Department
469-474-2435
MobilityDpt@STARtransit.org