STAR TRANSIT

Application for Eligibility

DISABLED RIDER PASS

This card will allow you to ride demand response/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 877-631-5278 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 or PO Box: _____

City, State, Zip: _____

Phone #: _____

Date of Birth: _____ ☐ **Male** ☐ **Female**

Emergency Contact: _____ **Phone #:** _____

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 Wheelchair		Walker/Rolator	
Picture/Alphabet Board		Power Wheelchair		White Cane	
Crutches		Large Power Wheelchair		Prosthesis	
Service Animal		Portable Oxygen Supply		Other	

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
877-631-5278
MobilityDpt@STARtransit.org