



## REDUCED FARE PROGRAM FOR INDIVIDUALS WITH DISABILITIES APPLICATION

<b>OFFICE USE ONLY</b>	
Date Received	_____
Date Processed	_____
Date Approved	_____
Date Denied	_____
Date Notified	_____
Status Code	_____

1. Applicant must have a disability and live in Murfreesboro to qualify.
2. If all spaces are not completed this form will be returned. In lieu of completing Sections 2 and 3, however, an applicant may attach an official letter from the Social Security Administration confirming that the applicant receives Supplemental Security Income (SSI).
3. Please read the entire application and print neatly or type; only one person per application.
4. Do not attach transportation requests or schedules.
5. Application may require 14 days for processing.

This application is available in accessible format. If you have any questions regarding this application or need assistance completing the form, please call (615) 217-6837, or TDD (615) 849-2689.

<b><u>Section 1—Personal Information</u></b>	
Date of Application: _____	
Name (Please Print): _____	
Address: _____	
City: _____	State: _____ Zip: _____
Home Telephone: _____	Work/Cell Telephone: _____
Birth Date: _____	Email Address: _____
<b>Emergency Contact</b> (Application will be returned if left blank.)	
Name: (Please Print): _____	
Address: _____	
Home Telephone: _____	Work/Cell Telephone: _____
Relationship: _____	

***I certify that information provided in this application is true, authorize the health care professional certifying this application to release information about my disability to ROVER, and agree to use my reduced-fare card, if granted, consistent with ROVER policy.***

Applicant's Signature: _____	
<b>If this application has been completed by someone other than the person requesting reduced-fare eligibility, that person MUST FULLY COMPLETE the following:</b>	
Name of Individual or Agency: _____	
Address: _____	
(City / State / Zip): _____	
Phone: Fax Number: _____	
Signed: _____	Date: _____

**IF YOU ARE NOT ATTACHING A LETTER FROM THE SOCIAL SECURITY ADMINISTRATION CONFIRMING THAT YOU RECEIVE SUPPLEMENTAL SECURITY INCOME (SSI), YOU AND YOUR HEALTH CARE PROVIDER MUST COMPLETE SECTIONS 2 AND 3, RESPECTIVELY.**

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## Section 2—Disability Information

1. Please describe your impairment and/or illness and check any applicable items below (examples include blindness, multiple sclerosis, heart condition ): \_\_\_\_\_

- a. Visually Impaired: Total \_\_\_\_\_ Partial \_\_\_\_\_ Vision: Right 20/\_\_\_\_ Left 20/ \_\_\_\_\_
- b. Hearing Impaired: \_\_\_\_\_
- c. Mentally or Developmentally Impaired: \_\_\_\_\_
- d. Wheelchair User: Powered \_\_\_\_\_ Manual \_\_\_\_\_ Scooter \_\_\_\_\_
- e. Crutches: Braces \_\_\_\_\_ Walker \_\_\_\_\_ Prosthesis \_\_\_\_\_ Other \_\_\_\_\_
- f. Other Mobility Limitations or Physical Impairments (please describe): \_\_\_\_\_

2. Do you require someone to assist you when you travel using transit? (It is a disabled rider's responsibility to provide a personal care attendant and a properly functioning common wheelchair. Rover drivers are only responsible to provide assistance when using the lift. No fare is charged for a personal care attendant riding with a disabled rider.) (*Do not leave blank*) YES \_\_\_\_\_ NO \_\_\_\_\_

### 3. Do you use any of the following aids? (Check all that apply)

\_\_\_\_\_ Wheelchair; if Your Wheelchair Is Larger Than a Common Wheelchair (30 Inches Wide; 48 Inches Long ; less than 600 lbs. when occupied), please describe it: \_\_\_\_\_

\_\_\_\_\_ Powered Scooter; scooters are not recommended for safe transportation on Rover buses. If you use a scooter, will you be able to transfer to a seat? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ Service Animal \_\_\_\_\_ Alphabet Board \_\_\_\_\_ Oxygen Tank

## Section 3—Health Care Professional Certification

This certification must be completed by a licensed or certified health care professional (see page 2 of ROVER reduced fare policy), and received by Rover within 60 days of the health care professional's signature. Information will remain on file with Rover and is not subject to public review.

Name of Health Care Professional: \_\_\_\_\_

License Number/State Issued: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City. State, Zip: \_\_\_\_\_

Check One: \_\_\_\_\_ Physician: (Specialty) \_\_\_\_\_

\_\_\_\_\_ Physician's Assistant \_\_\_\_\_ Nurse Practitioner \_\_\_\_\_ Audiologist \_\_\_\_\_ Podiatrist

\_\_\_\_\_ Optometrist \_\_\_\_\_ Licensed Clinical Psychologist \_\_\_\_\_ Certified School Psychologist

\_\_\_\_\_ Licensed Occupational Therapist \_\_\_\_\_ Licensed Physical Therapist

Expected duration of applicant's disability:

\_\_\_\_\_ Temporary: Short Term conditions likely to improve within one year

\_\_\_\_\_ Long-Term: Condition with potential for improvement or long periods of remission

\_\_\_\_\_ Permanent: Conditions with absolutely no expectation of improvement

I certify that the applicant is affected by the impairment/illness described, and as a result, requires the assistive devices described, and is unable to use mass transportation services as effectively as persons who are not so affected.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Return Application to:**

ROVER, 111 West Vine Street, P.O. Box 1139, Murfreesboro, TN 37133-1139