REDUCED FARE PROGRAM FOR INDIVIDUALS WITH DISABILITES APPLICATION

OFFICE USE ONLY

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.

Section 1—Personal Information

Date of Application: ______________

Name (Please Print): ______________

Address: ______________

City:______________ State: ______________ Zip: ______________

Home Telephone: ______________Work/Cell Telephone: ______________

Birth Date: ______________ Email Address: ______________

Emergency Contact (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: ______________

If this application has been completed by someone other than the person requesting reduced-fare eligibility, that person MUST FULLY COMPLETE the following:

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:___________________________________

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____ 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

____ Other Assistive Devices. If yes, please describe: ____

____

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 log 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, 4765 Florence Road, Murfreesboro, TN 37129