



Laredo Transit Management, Inc.

REDUCED FARE PROGRAM

Fixed Route Bus Service Only

For those who are age 62 and older or who have a disability

[You do not need to complete an application if you have a **Medicare Card**, and are **over the age of 62**]

Application for Persons with Disabilities

INSTRUCTIONS

APPLICANT: Fill out the information in the “To Be Completed by Applicant” section and submit to licensed physician for certification.

PHYSICIAN OR AGENCY: Please complete all items (Item1-8) in section marked “Certified Medical Doctor by the State of Texas”.

Unless a category is specifically checked off and, in the case of “Ambulatory Disable” more specifically categorized, we cannot accept the application. If there is a category that your patient fits into, he or she is not eligible for the program.

Complete Application should be returned to:

Laredo Transit Management, Inc. Reduced Fare Program
1301 Farragut St. 1st Floor
Laredo Texas 78041

or

Faxed to: by the physician Office to (956) 795-2258

Once applicant has been approved, they will be notified and be required to come into one of our administrative offices and obtain a photo ID card. The process may take up two weeks upon receipt of the application to be approved for eligibility. You may call (956) 795-2280 ext. 221 with any questions or concerns regarding your application status. For applicants below the age of 62 you must recertify every two years.

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ELIGIBILITY CRITERIA

General Provisions:

1. The Eligibility Criteria listed on page 2 of the application are the sole basis for the determination of a disability for the Laredo Transit Management, Inc. Reduce Fare Program.
2. A reduced fare photo identification (I.D.) card will be issued for eligible person using this program. The I.D. card is only valid until expiration date shown on card.
3. Medicare cardholders will still receive discount for fixed route, although not all Medicare cardholders qualify for the reduced fare program.
4. Laredo Transit Management, Inc. reserves the right to verify Certification Forms by contacting persons completing the forms including medical doctors.
5. Any fees charged for the completion of The Certification Form are not the responsibility of Laredo Transit Management, Inc.
6. Certification Forms will be kept confidential and on file at Laredo Transit Management, Inc. During the period of eligibility.
7. I.D. fee of \$2.00 is required for all cards and will be renewed on a two-year basis unless temporary eligibility status is affirmed.
8. The criteria for eligibility in the application are in accordance with the following definition:

“A person with a disability means any individual who, by reason of illness, injury, age, congenital malfunction, or other permanent or temporary incapacity or disability, is unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively or design to utilize mass transportation facilities and services as effectively as persons who are not so affected.”

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Application for Persons with Disabilities

TO BE COMPLETED BY APPLICANT

1. Name _____
(Last) (First) (M.I.)

2. Address _____
(Street) (Apt.)

(City) (State) (Zip)

3. Sex: () Male () Female 4. Date of Birth _____/_____/_____

5. Social Security Number _____ - _____ - _____ (Minimum – Last 4 digits required)

6. Phone Number _____

7. Signature _____

Certified Medical Doctor by the State of Texas Is Required for Eligibility.

Print

1. Name _____ Phone # _____

2. Office Address _____
(Street)

(City) (State) (Zip)

3. MD Licensing Identification Number _____

4. Signature _____

5. Nature of Disability that may determine eligibility status: Please print or type legibly

PROFESSIONAL CERTIFICATION (continued)

ELIGIBILITY CRITERIA

6. The impairment or disability is considered:

Permanent () Temporary () Estimated Period of Disability From _____ to _____
(Date) (Date)

7. () Non-Ambulatory

A person whose incapacity or disability will allow that person to walk, even with the assistance of devices, but with or without the assistance of an attendant, has a personal mobility and may be considered independent with the use of a wheelchair that can afford the appropriate public transportation services. **Note: Laredo Transit Management, Inc may not be able to accommodate you if your wheelchair or scooter is longer than 48” or wider than 30” or if your total weight with your wheelchair is more than 600 pounds.**

8. () Semi-Ambulatory

Any person whose incapacity or disability will not allow that person to walk without the assistance of walkers, crutches, canes, braces, artificial legs, or other such adaptive devices, and for whom use of appropriate public transportation services is a reasonable expectation.

Type of mobility aid used _____

9. () Ambulatory

Any person whose disability relates to a degree of visual, audio, physiological, mental or psychological disability or impairment as specified below, and for whom private personal transportation poses an unreasonable difficulty or impairment.

() Cerebrovascular accident (stroke)

() Severe Pulmonary disability/Cardiac disability

() Sight disability – those persons whose vision in the better eye after correction is 20/200 or less: and those persons whose visual field is contracted (commonly know as tunnel vision) to 10 degrees or less from a point of fixation, or so the widest diameter subtends an angle no greater than 20 degrees.

() Hearing – loss is 90 dba or greater in the 500, 1000, 2000 Hz ranges.

() Faulty coordination from brain, spinal, peripheral nerve injury or chronic arthritic condition.

() Epilepsy – petit and grand mal

() Autism

() Cerebral palsy

() Mental Retardation (a state of significant **subnormal** intellectual development with reduction of social competence in a minor or adult person).

() Mental Illness (a mental disease to such extent that a person so afflicted requires care and treatment for their own welfare or the welfare of others or the community).

() Other – Please specify the disability that impairs mobility.

Details of ambulatory disability: _____

For office use only: [] Approved [] Denied By _____ Date _____
Notification Mailed Date: _____ By _____ Date _____