



# DISCOUNT FARE APPLICATION

## DISCOUNT FARES ARE APPLICABLE TO:

**Persons with disabilities** (Complete Sections 1 and Section 2 and/or 3)

**Persons 65 and older** (Complete Sections 1 and 4)

**Medicare recipients** (Complete Sections 1 and 5)

**Students:** Defined as persons 12 or older who are enrolled in a public, private or charter middle, junior high or high school, including home school programs (Complete Sections 1, 4 and 6)

## SECTION 1: APPLICANT INFORMATION

Applicant Name \_\_\_\_\_ Applicant Birthdate \_\_\_\_\_

Applicant Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

## SECTION 2: DISABILITY DISCOUNT FARE AGENCY VERIFICATION

**Applicant must qualify under one of the following categories:**

Certified for 80 percent of more disability allowance through the U.S. Veterans Administration

Certified for Social Security disability or S.S.I. disability payments

Certified by the Arkansas Department of Human Services Division of Services for the Blind

Certified by the Arkansas Career Education Arkansas Rehabilitation Services Office for the Deaf and Hearing Impaired

**This section to be completed by a representative from the U.S. Veterans Administration, Social Security Administration, ADHS Division of Services for the Blind or the ACE ARS Office for the Deaf and Hearing Impaired.**

**Agency Verification Stamp:**  
Please provide the appropriate agency official verification stamp.

Agency Representative Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agency Representative Authorized Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

## SECTION 3: DISABILITY DISCOUNT FARE HEALTH CARE REPRESENTATIVE VERIFICATION

**This section to be completed by a physician, licensed health care provider, licensed rehabilitation counselor, licensed social worker or orientation mobility specialist.**

I, \_\_\_\_\_, hereby certify that \_\_\_\_\_ has a disability that qualifies for a Rock Region METRO transportation discount fare.

Health Representative Authorized Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Health Representative Title \_\_\_\_\_

Health Representative Licensing Organization and License Number: \_\_\_\_\_

Health Representative Practice/Clinic Name: \_\_\_\_\_

Practice/Clinic Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Practice/Clinic Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Health Representative Work Email Address: \_\_\_\_\_

## SECTION 4: AGE DISCOUNT FARE VERIFICATION

Please provide a photo ID and one of the following documents for proof of age:

- Driver's License
- Arkansas Identification Card
- Birth Certificate
- Voter Registration Card
- Medical Record from Authorized Agency or Practice
- Other (Rock Region METRO reserves the right to accept or deny alternate forms of proof of age.)

## SECTION 5: MEDICARE RECIPIENTS DISCOUNT FARE VERIFICATION

Please provide a photo ID, your Medicare card and/or one of the following forms of identification.

(Extra identification only needed if applicant doesn't have a driver's license.)

- Driver's License
- Arkansas Identification Card
- Birth Certificate
- Voter Registration Card
- Medical Record from Authorized Agency or Practice
- Other (Rock Region METRO reserves the right to accept or deny alternate forms of proof of identification.)

## SECTION 6: STUDENTS 18 OR YOUNGER DISCOUNT FARE VERIFICATION

This section to be completed by a school representative.

I, \_\_\_\_\_, hereby certify that \_\_\_\_\_ is a current student at \_\_\_\_\_ and qualifies for a Rock Region METRO transportation discount fare.

School Representative Authorized Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

School Representative Title: \_\_\_\_\_

School Name: \_\_\_\_\_ School Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

School Representative Work Email Address: \_\_\_\_\_

**SUBMIT COMPLETED APPLICATIONS** to Rock Region METRO River Cities Travel Center, 310 E. Capitol Ave., Little Rock, AR 72202. Photo identification cards will be issued to applicants with approved applications. Contact Donna Bowers at 501-375-6717 with any questions.

## FOR OFFICE USE ONLY

Approved  Denied

Discount Fare Pass Expiration Date \_\_\_ / \_\_\_ / \_\_\_\_\_

Discount Fare Type:

- Persons with disabilities
- Persons 65 and older
- Medicare recipients
- Students 18 and younger

Authorized Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_