Rock Region METRO

DISABILITY DISCOUNT FARE APPLICATION

DISCOUNT FARES ARE APPLICABLE TO: **Persons with disabilities . Complete Section 1 and Section 2 and/or 3.**

SECTION 1: APPLICANT INFORMATION

Applicant Name _____ Applicant Birthdate _____

Applicant Address _____ City _____ State _____ Zip Code _____

Applicant 10-Digit Phone Number ( ) _____ Applicant Email _____

Preferred Communication Method: ❑ Phone or ❑ Email

Applicant Signature _____ Date: __ __ / __ __ / __ __ __ __

SECTION 2: DISABILITY DISCOUNT FARE AGENCY VERIFICATION

Please provide one of the following documents for proof of disability status.

❑ Certified for 80 percent or more disability allowance through the U.S. Veterans Administration
Qualifying documentation is a VA Summary of Benefits Letter

❑ Certified for Social Security disability or S.S.I. disability payments
Qualifying documentation is a SSI/SSDI Award Letter

❑ Certified by the Arkansas Department of Human Services Division of Services for the Blind
Qualifying documentation is an Arkansas Rehabilitation Services Eligibility Letter or Division of Services for the Blind Eligibility Letter

❑ Certified by the Arkansas Career Education Arkansas Rehabilitation Services Office for the Deaf and Hearing Impaired
Qualifying documentation is an Arkansas Rehabilitation Services Eligibility Letter or ODHI Deaf and Hearing Impaired Eligibility Letter

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

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 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: _____

SUBMIT COMPLETED APPLICATIONS

to Rock Region METRO River Cities Travel Center Sales Office, 310 E. Capitol Ave., Little Rock, AR 72201. Within five business days of receiving a completed application, METRO will inform the applicant of the results of their eligibility determination. If an application is approved, the applicant may obtain an Honored Citizen photo identification card at the River Cities Travel Center Sales Office, 310 E. Capitol Ave., Little Rock, AR 72201. Contact the METRO eligibility specialist at 501-375-6717 with any questions.

FOR OFFICE USE ONLY

All application information has been completed by the applicant and collected by METRO.

Authorized Signature of METRO Employee: _____ Date: __ __ / __ __ / __ __ __ __

❑ **Approved** ❑ **Denied** **Discount Fare Pass Expiration Date** __ __ / __ __ / __ __ __ __

Application Received

Authorized Signature of METRO Employee: _____ Date: __ __ / __ __ / __ __ __ __

Application Verified/Approved/Denied

Authorized Signature of METRO Employee: _____ Date: __ __ / __ __ / __ __ __ __

Applicant Notified of Determination

Authorized Signature of METRO Employee: _____ Date: __ __ / __ __ / __ __ __ __