



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 Toni Wright, 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: ___ / ___ / _____

