Greater Cleveland Regional Transit Authority

Application for Disabled and Senior Discount Fare Program

ELIGIBILITY:
To qualify for the Greater Cleveland Regional Transit Authority's Fixed Route Disability Program, you must have a physical or mental disability/impairment. A health-care professional must verify the disability/impairment.

TO APPLY:

1. Applicant must fill out Section I.

2. If you have a Service Connected Veterans ID, or if you have a valid Medicare card, bring either card and complete Section I only.

3. If you are 65 or older, you may present a valid photo ID and complete Section I only.

4. A medical professional or licensed social worker must complete Section II.

5. Bring the application and fee to 1240 West 6th Street, along with a valid photo ID.

Discount Fare ID- **$5.00** Senior ID- **$3.00** Replacement- **$5 Discount Fare**
$3 Senior

EXCLUSIONS:

A person whose sole incapacity is pregnancy, obesity, acute or chronic alcoholism, or drug addiction, is not eligible for the Fixed Route Discount Fare program

SECTION I: APPLICANT INFORMATION

Please PRINT clearly.

Name: Last _____ First _____ M.I. _____

Address: _____Apt #_____

City: _____State:_____ Zip Code: _____

Phone:_____E-mail address_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Circle One: V.A. Eligibility Medicare Eligibility Senior Eligibility

Applicant Disability/Impairment_____

By signing this application, I certify that I have been truthful in answering this form and that the information that I have provided is correct to the best of my knowledge.

Applicant Signature_____ Date_____

SECTION II:
MEDICAL PROFESSIONAL CERTIFICATION OR AGENCY

Please PRINT: All information in this section must be completed. Only sign if you are treating the applicant for a qualifying disability.

Nature of disability: ☐ Physical ☐ Psychological ☐ Developmental

Applicant's Disability/ies_____

How the disability/impairment does significantly affects applicant's ability to use fixed route service:

_____

_____

The impairment or disability is considered:

☐ Permanent ☐ Temporary

If temporary, estimated duration of Disability (date): ____ / ____ / _____

PROFESSIONAL CERTIFICATION:

Name:_____

Address:_____

City:_____State:_____ Zip Code:_____

Office Telephone Number: _____Fax Number:_____

License/Certification Number:_____State:_____

Please indicate Profession: ☐ Physician ☐ Licensed Social Worker

I certify that the applicant is disabled or impaired as defined by the above criteria and that the information I have provided is true and correct. I am currently treating the applicant for the disability or impairments indicated above. I understand that false certification may be reported to the licensing jurisdiction under the State of Ohio or appropriate code for state of license/ certification.

Signature_____ Date_____

If you need assistance to complete this form, please call ADA Registration at (216) 566-5124