Reduced Fare Card Application

Transpo offers reduced fare on its fixed route service to qualifying persons with physical or cognitive disabilities.

To apply for a Reduced Fare Card, please complete the following application and return to:

Transpo Reduced Fare Program
1401 S. Lafayette Blvd
South Bend, IN 46613

It is important to complete all parts of this form; incomplete applications will be returned. All information will be kept confidential.

Please note: If you have a ***Medicare*** card, you may use your card as identification for reduced fares and a Reduced Fare Card is not needed.

Medicaid cards are not valid for reduced fares.

Please type or print:

Last Name: _____ First Name: _____ Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: _____ Evening Phone: _____

Date of Birth (XX/XX/XX): _____

Do you have a **Medicare** card? _____ Yes (enclose a copy) _____ No

_____

FOR OFFICE USE ONLY

Application Received: _____ Professional Verification Mailed: _____ Received: _____

Mobility Aid: _____ Determination: _____

Determination Mailed: _____ Reduced Fare Card Number: _____

1. What is the nature of your disability or health condition? (Be specific)

_____

_____

_____

_____

_____

2. Is your condition temporary?

_____ Yes If temporary, how long do you expect it to last? _____

_____ No

3. Which of these mobility aids or equipment do you use to help you get where you need to go? Please check all that apply to you.

_____ None
_____ Powered or manual wheelchair
_____ Powered scooter/cart
_____ Crutches
_____ Cane
_____ Personal care attendant
_____ White cane
_____ Walker
_____ Service Dog
_____ Route identification cards
_____ Picture board
_____ Other _____

To properly evaluate your request for a Reduced Fare Card, it may be necessary to contact a physician or other health care professional to confirm the information you have provided. Please complete the following authorization:

Health Care Provider Name: _____

Title: _____ Agency/Clinic: _____

Address: _____

City/State/ Zip: _____ Phone: _____

Your Name (Print): _____

Your Name (Signature): _____ Date: _____

Applicant Verification

1. Applicant Signature

_____ I certify that the information provided in this application is true and correct. I understand all information will be kept confidential. I understand that for confirmation, Transpo may contact my health care professional whom I listed on the application.

Applicant Signature: _____ Date: _____

2. Person completing form if other than applicant (please check one):

_____ I certify that the information provided in this application is true and correct based upon information given to me by the application.

_____ I certify that the information provided in this application is true and correct based upon my knowledge of the applicant's health condition or disability.

Full Name: _____

Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

Daytime Phone: _____

Signature: _____ Date: _____