

City Utilities of Springfield, Missouri
1505 Boonville, Springfield, MO 65803 Phone 831-8782
Application for Reduced Bus Fares

Card # _____
Date Issued _____
Expiration Date _____
Eligibility Code _____

If you are a Medicare Card Holder or age 65 or older, complete only the top section.

Information obtained in this certification process will be used only by the City Utilities Transit Department for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency. Professional verification of disability is required.

Name _____
Date of Birth _____ Telephone Number (Home) _____ (Work) _____
Address _____
City _____ State _____ Zip _____
Medicare Card Number _____ Medicaid Card Number _____

In order to allow City Utilities to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form.

The following (check one)

Physician Health Care Professional Rehabilitation Professional

Is familiar with my disability and is authorized to provide information to City Utilities that is required to complete this certification.

Name _____
Address _____ State _____ Zip _____
Telephone Number _____

If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name _____
Address _____ State _____ Zip _____
Daytime Telephone _____
Signature _____ Date _____

Please describe your disability.

Is this condition temporary? Y N If yes, expected duration until _____

Does your disability occasionally prevent you from using fixed route bus service?
(If "YES" please explain completely.)

 Y N

How far do you live from the nearest fixed bus line? _____

Are there any other aspects of your disability (i.e., seizures, disorientation, etc.) of which we need be aware?

Do you use any of the following aids to mobility?

- Manual Wheelchair Electric Wheelchair Powered Scooter Cane
 Crutches Personal Care Attendant Service Animal

If you use any of the mobility aids (as checked above) or if you do not, please answer the following questions:

	(check one)		
	Yes	No	*Sometimes
Can you travel 200 feet without the assistance of another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you travel ¼ mile without the assistance of another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you climb three 12-inch steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you wait outside alone for ten minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Please briefly Explain each "**Sometimes**" selection. _____

I hereby certify that the information given above is correct.

Signature

Date

Request for Professional Verification

Dear _____

The attached authorization form has been submitted by _____ who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law requires that City Utilities Transit Services provide reduced bus fare to persons who are Medicare eligible, age 65 or older, or those that are disabled. The information you provide will allow us to make an appropriate evaluation of this request. Thank you for your cooperation in this matter.

Capacity in which you know the applicant: _____

Medical Diagnosis of condition causing disability: _____

Is the Condition temporary? Y N Expected duration until _____

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If this person has a disability affecting mobility, is he/she:

	Yes	No	(check one) Sometimes
Able to walk 200 feet without the assistance of another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to walk ¼ mile without the assistance of another person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to climb three 12-inch steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to wait outside alone for ten minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Please give brief explanation for each "Sometimes" selection above.

Does this person use any mobility aids? If so what: _____

If this person has a visual impairment, is he/she able to:

	Yes	No
Travel unassisted on routine trips after receiving adequate instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Travel with the aid of a service animal?	<input type="checkbox"/>	<input type="checkbox"/>

If this person has a cognitive disability, is he/she able to:

(check one)

Yes

No

Give addresses and telephone numbers upon request?

Recognize a destination or landmark?

Deal with change in routine?

Ask for, understand, and follow directions?

Adequately deal with crowded areas?

Is there any other aspect of the disability of which C.U. Transit Services should be aware? Please describe:

Your Name: _____

Office Address: _____ Phone #: _____

Signature _____

ELIGIBILITY CHECKLIST FOR REDUCED BUS FARE

_____ Medicare Card Holder – (Complete top of attached application only and attach a copy of your Medicare Card)

_____ Age 65 or older – (Complete top of attached application only and attach a Copy of your Medicare Card or verify proof of age)

_____ Disabled – is defined by the Social Security Administration and Division of Family Services as an individual's inability to be gainfully and substantially employed for one year or longer due to a physical or mental incapacity.

_____ A. I receive SSD, SSI or VA disability – (Complete top of attached application only and attach a copy of SSA or VA proof of disability)

_____ B. My disability can be professionally verified – (Please complete the entire attached form and be sure to list a professional we can contact to verify your disability)