Regional Transportation Authority

REDUCED FARE PERMIT

RIDE FREE PERMIT

PERSONS WITH DISABILITIES PERMIT APPLICATION

RTA Persons with Disabilities Ride Free Permit

The RTA Persons with Disabilities Ride Free Permit allows qualifying customers with disabilities to ride at no cost on CTA, Metra and Pace fixed route bus and rail service. Applicants must be age 64 or under and enrolled in the Benefit Access Program administered by the Illinois Department on Aging (DOA). For more information about the DOA Benefit Access Program visit www.illinois.gov/aging or call 1-800-252-8966.

RTA Persons with Disabilites Reduced Fare Permit

The RTA Persons with Disabilities Reduced Fare Program allows individuals with disabilities age 64 or under, who are not eligible for the DOA Benefit Access Program, to ride on CTA, Metra and Pace fixed route bus and rail service at a reduced rate.

Who Qualifies for a Persons with Disabilities Reduced Fare Permit?

A. Applicants with disabilities receiving Social Security or SSI benefits

B. Medicare card holders receiving Social Security benefits, including persons who do not have a disability and are under the age of 65

C. Veterans receiving service-related disability benefits

D. Applicants with physical, hearing, mobility, mental, visual or cognitive disabilities*

** Persons with episodic disorders may be eligible for a RTA Reduced Fare Permit based on functional abilities when the disorder is not under control.*

IF APPROVED, APPLICANTS WILL RECEIVE THEIR RTA RIDE FREE PERMIT OR REDUCED FARE PERMIT WITHIN 3-4 WEEKS.

RTA, PO Box 8621, Fort Wayne, IN 46898-8621, Phone: 312-913-3110

RIDE FREE APPLICATION INSTRUCTIONS

- Apply for the Illinois DOA Benefit Access Program:
  - From any computer, visit the Illinois Department of Aging Benefit Access Program website at www.illinois.gov/aging and click on the "Benefit Access" tab
  - For in-person assistance, call the Illinois Department on Aging to locate a location near you that can provide assistance at (800) 252-8966
- Complete page 3 of this application
- Send the application, a copy of your current government issued ID card (such as a driver's license, state ID, passport or alien registration card) and a 2" by 2" color photo that clearly shows your face to the RTA in the envelope provided or mail to RTA, PO Box 8621, Fort Wayne, IN 46898-8621

REDUCED FARE APPLICATION INSTRUCTIONS

- Complete page 3 of this application
- Provide proof of disability/Medicare eligibility
- If you using a doctor's verification as proof of disability, please complete page 4 of this application and include a doctor's statement
- Send the application, a copy of your current government issued ID card (such as a driver's license, state ID, passport or alien registration card), a 2" by 2" color photo that clearly shows your face and your doctors statement (if applicable) to the RTA in the envelope provided or mail to RTA, PO Box 8621, Fort Wayne, IN 46898-8621

PROOF OF DISABILITY/MEDICARE ELIGIBILITY

Choose and submit one of the options listed below:
(DOCUMENTS VERIFYING DISABILITY MUST NOT BE MORE THAN 12 MONTHS OLD)

A. Social Security Validation. Applicants must provide a current printout of their Social Security Benefits statement that states the words, "disabled individual" or the letters "DI" after their Social Security number or claim number.*

B. Medicare Validation. Applicants must submit the following two (2) forms:
1. A copy of their Medicare card (not Medicaid)

— AND —

2. A current Social Security Benefit Statement*

C. Veterans Validation. If the applicant has a service-connected disability, he/she must submit a copy of a benefit letter from the Veterans Administration.

D. Doctors Validation. Applicant must submit the following two (2) forms:
1. The back of this application form completed by their doctor

— AND —

2. A doctor statement describing the nature of their disability on professional letterhead or prescription form.

**A benefit verification letter or Social Security Benefit Statement can be obtained by calling the Social Security administration office at 800-772-1213, by visiting any Social Security Administration Office, or online at www.ssa.gov/myaccount.*

APPLICATION: RIDE FREE PERMIT | REDUCED FARE PERMIT

All applicants must complete this page:

Status (check one):
- ☐ New applicant
- ☐ Renewal - Card #: _____ (begins with a D or F on your card)

Applying for (check one):
- ☐ Ride Free Permit (I am enrolled in the Benefit Access Program)
- ☐ Reduced Fare Permit (I am not enrolled in the Benefit Access Program)

Please print clearly and complete all information:

Legal Name: FIRST _____ M.I. _____ LAST _____ (SUFFIX) _____

Email Address: _____

Mailing Address: (include all information required for mail delivery)

STREET ADDRESS or PO BOX #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Date of Birth (mm/dd/yyyy): _____ / _____ / _____

Social Security #: _____ - _____ - _____

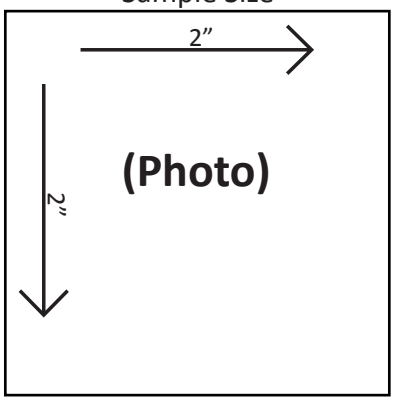
Telephone #: ( ) _____

Be sure to include ALL of the following items:

- ☐ 2” by 2” color photo (clearly shows face)
- ☐ Proof of disability (for Persons with Disabilities Reduced Fare Permit)
- ☐ Clear copy of both sides of current government-issued ID card

(Any one of the following: Driver’s License, Passport, State issued ID, U.S. Immigration, Alien registration card, or any other official government ID with your picture, date of birth and signature)

Sample Size



Application must be signed: I understand that the purpose of this certification is to determine eligibility for the RTA Reduced Fare or Ride Free Permit Program, and agree to release the information from the Illinois Department on Aging Benefit Access Program for that purpose. The information requested on this application is exempt from public disclosure to the extent permitted by paragraph 207 of the Illinois Freedom of Information Act (5 ILCS 140/1 ET SEQ.). I understand that any information falsely presented on the application may result in my prosecution to the fullest extent allowable under the law. I understand that if I am issued an RTA Reduced Fare or Ride Free Permit that the permit is for my personal use only, and that if I allow another person to use my card, then the card could be revoked, I could be removed from the program, and I may be prosecuted to the fullest extent allowable under the law.

Date: _____ Signature: _____

CENTER USE ONLY

CENTER CODE: _____ **TAKEN BY: (INITIALS)** _____

ATTACH HERE

Only applicants applying for a Persons with Disabilities Reduced Fare permit, using a doctor's statement as proof of disability, must complete this page:

TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

Applicants do not qualify if their sole condition is pregnancy, obesity, impairment due to drugs/ alcohol abuse, or a dysfunction that can be controlled through medication. Please check the appropriate box. Applicant is eligible for a Reduced Fare Permit if one of the following criteria listed below applies:

- ☐ A physical disability, including but not limited to: respiratory, cardiac, or neurological disabilities, a person receiving dialysis, living with AIDS, MS or a chronic progressive debilitating disease
- ☐ A disability that effects mobility, including but not limited to: people who are non-ambulatory, use a mobility aid, have arthritis or an amputation
- ☐ A person who is blind or visually impaired
- ☐ A person who is deaf or has a hearing disability (Audiologist approval only)
- ☐ An intellectual disability or developmental disability
- ☐ A psychiatric disability that is chronic in nature

Please indicate the duration of disability:

☐ 6 mths ☐ 9 mths ☐ 1 year ☐ 4 years

- ☐ Applicant's impairment does not meet any of the functional limitations listed above. Therefore, I cannot certify that the applicant's impairment meets the criteria for receiving the RTA Reduced Fare Permit at this time.

If applicant meets the eligibility criteria, please attach a statement on your professional letterhead or prescription form (please type or print) noting the diagnosis of the applicant and describing in detail why he/she meets the eligibility criteria. Photocopies and form letters are not acceptable. This statement is required in order to process this application. **Check One:**

☐ Physician ☐ Psychiatrist ☐ Optometrist ☐ Audiologist ☐ Chiropractor

☐ Psychologist ☐ Physician Assistant ☐ Nurse Practitioner

NAME (PLEASE PRINT):.....

BUSINESS ADDRESS:..... CITY:..... STATE:..... ZIP CODE:.....

PATIENT'S NAME (PLEASE PRINT):..... D.O.B:.....

WRITE YOUR LICENSE NUMBER:..... - ..... STATE:.....

This number will be verified by your State Department of Professional Regulation. **Please note temporary numbers are not accepted.**

Information falsely presented on this application by a licensed medical professional may result in their prosecution to the fullest extent allowable under the law. In addition, any falsification of information on this form may be considered grounds for revocation, suspension, reprimand or other disciplinary action. RTA reserves the right to (1) contact the licensed medical professional to verify the information provided, (2) make the final determinations on an applicant's eligibility for a Reduced Fare Permit and (3) have an applicant submit to a second exam by a licensed medical professional selected by the RTA. I hereby certify to the best of my knowledge the information on this application form is true and correct.

Date: ..... Signature: .....