Denton County Transportation Authority
604 East Hickory
Denton, Texas 76205

TEL: (940) 243-0077; FAX: (940) 387-1461

APPLICATION FOR SENIOR/DISABLED REDUCED FARE

The determination of whether a person is "disabled" with the meaning of the foregoing definition will be made on the basis of submitted evidence. Certification by a physician or approved certifying agency is essential to the application. Applicants will have to arrange for the physician's or agencies services at their own expense. We reserve the right to require proof of disability in addition to the physician's or agencies opinion.

New Applicant

☐ I request that a DCTA Customer Service Representative take a photo and create my card on site.

☐ I have sent a recent color photo for use in preparation of my I.D. card emailed to CSR@dentontransit.com. (Please do not send Driver's License)

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Last Name: _____

First Name:_____

Permanent Street Address:_____

Apt. #:_____

City/State/Zip Code:_____

Date of Birth:_____

Phone:_____

Email: _____

Signature of Applicant or Guardian:_____

Section C: Definition of Disability & Eligibility

1. A person is defined as having a disability by reason of illness, injury, congenital malfunction, or other permanent or temporary incapacity or disability that is unable without special facilities or special planning or design to utilize DCTA's bus facilities and services effectively.
2. Age 65 or older.
3. Medicare cardholder—anyone in possession of a Medicare card is eligible for Reduced Fare.

OFFICE USE ONLY

Determination: ☐ Approved ☐ Denied

Expiration Date:
☐ 3-years ☐ Other _____

Reviewed By: _____

Date of Review: _____

Please complete either Section A—OR—Section B but not both.

Section A: Disabled Certification

NAME OF DISABILITY: Please check one or more that apply

____ Paraplegic	____ Multiple Sclerosis	____ Stroke
____ Arthritis, Hip or Leg	____ Quadriplegic	____ Visually Impaired
____ Arthritis (other)	____ Cerebral Palsy	____ Cognitive Impairment

____ Other (Specify) _____

NATURE OF MOBILITY PROBLEM: Please check one or more that apply

_____ Paraplegic	_____ Multiple Sclerosis	_____ Stroke
_____ Arthritis, Hip or Leg	_____ Quadriplegic	_____ Visually Impaired
_____ Arthritis (Other)	_____ Cerebral Palsy	_____ Cognitive Impairment

_____ Other (Specify) _____

CERTIFICATION: (Completed by Physician or other Approved Certifying Agency)

I certify that this applicant is _____, is not _____, disabled as listed in Section's A of this form.

In my professional opinion this person is: _____ ABLE, _____ ABLE WITH GREAT DIFFICULTY, _____ UNABLE to use Denton Transit buses due to disability.

How does their disability affect riding public transportation?

_____

_____

_____

SIGNATURE OF PHYSICIAN: _____ ***DATE:*** _____

PHYSICIAN'S PRINTED FULL NAME: _____ ***LICENSE #:*** _____

ADDRESS: _____

PHYSICIAN'S CONTACT NUMBER: _____

FAX #: _____

SIGNATURE OF AGENCY OR EXAMINER: _____ ***DATE:*** _____

PRINTED FULL NAME: _____

AGENCY OR ORGANIZATION _____ ***TITLE:*** _____

ADDRESS: _____

CONTACT NUMBER: _____

FAX #: _____

Section B: Senior Citizen Certification

I certify I am 65 years of age or older as of the date of this application.

SIGNATURE: _____ **DATE:** _____