



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.

Applicant

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

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

A \$5.00 fee will be charged for all replacement cards.

☐ 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:** _____