BENZIE BUS
CONNECTING PEOPLE TO COMMUNITY

Special Services Application

Reduced Fare Application
Public Transit Customer with a Disability

To be certified by a licensed medical professional only

231.325.3000 office
231.325.3007 fax
14150 US Highway 31
Beulah, Michigan 49617
www.benziebus.com

Instructions

Applicant

Please fill out Section I, and then submit to a licensed Medical Professional, such as a physician, physical or occupations therapist, mental health professional, or rehabilitation professional to complete Section III. If you require a Personal Care Aide, please have your aide complete Section III.

Eligible applicants will receive a permanent or temporary Reduced Fare ID Card after the physician returns the completed application to the Benzie Transportation Authority. The ID card must be presented to the driver when boarding the bus.

Reduced Fare ID Cards are valid until the date shown on the card.

The Benzie Transportation Authority reserves the right to verify certification forms and will contact the proper authorities and report any fraud detected.

The Benzie Transportation Authority reserves the right to work directly with local agencies and entities to certify recipients which meet eligibility requirements for the Reduced Fare ID Card.

Licensed Medical Professionals

Please complete **Section II** and mail or fax this application to:

Benzie Transportation Authority
14150 US Highway 31
Beulah, MI 49617
Fax: 231-325-3007

Exclusions

Examples, not a complete list.

1. Pregnancy (excluding abnormal complications)
2. Short term ailments or illnesses
3. Environmental, economic, cultural disadvantages, age, homosexuality, bisexual lifestyle, compulsive gamblers, or those having a prison record
4. Acute or chronic alcoholism or drug addiction (except those in recovery programs)

BENZIE BUS
CONNECTING PEOPLE TO COMMUNITY

Section I – to be completed by applicant- please print clearly

Applicants Name ____

Home Address ____

City ____________________________ Zip Code ________________________

Home Phone _____________________ Work Phone _____________________

Please indicate your disability ___ Physical ___ Mental ___ Visual

Please indicate the aids used by passenger for mobility.

___ Manual Wheelchair ___Amigo ___ Electric Wheelchair
___ Aide or Helper ___Guide Dog or other Service Animal
___ Crutches/Cane ___ Portable Oxygen tank or respirator

Please indicate any other information that we should consider (i.e. seizures, etc.)
____
____

I certify that the information stated above is correct to the best of my knowledge. I authorize the completion of Section II and the release of this information and related information pertinent to my application to the Benzie Transportation Authority.

Applicant Signature ____________________ **Date** _________________________

If Section I was completed by anyone, other than applicant, please complete the information below; (please print clearly)

Name ____________________________Relationship to applicant _____________

Address ____

City ________________ Zip Code ____________ Phone ____________________

Signature ______________________________ **Date**_____________________

Section II

The professional completing this Section should be a Licensed Medical Professional, such as a medical physician, physical or occupations therapist, mental health professional, or rehabilitation professional.

The Americans with Disabilities Act (ADA) has a three (3) part definition of disability. Under ADA, and individual with a disability is a person who:

1. Has a physical or mental impairment that substantially limits one or more major life activity; or
2. Has a record of such impairment; or
3. Is regarded as having such an impairment.

A physical impairment is defined by ADA as “any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin and endocrine.”

Neither ADA, nor the regulations that implement it, list all the diseases or conditions that are covered because it would be impossible to provide a comprehensive list, given the variety of possible impairments.

The applicant’s impairment(s) or disability is considered:

Permanent:___________ Temporary:___________ None:________________

If Temporary, estimated time of disability? From ________ to ___________

Does this person’s disability require that they use a Personal Care Aide in order to use public transit? Yes __________ No___________

Please indicate if the applicant is able to:

_____ Recall their address
_____ Recall their phone number
_____ Sign his/her name
_____ Interact with others
_____ Recognize streets and bus numbers
_____ Deal with change/unexpected situations
_____ Understand and ask for directions
_____ Climb steps of a bus using a hand rail

Is this person capable of transferring buses to reach his/her final destination?
☐ **Yes** ☐ **No**

Name:____________________________________ Title________________________

Medical Facility Name:____

Address:____

Signature:_________________________________ Date________________________

Section III – to be completed by Personal Care Aide (please print clearly)

Personal Care Aide

I, ____certify that I am
(print name)
____________________________________'s Personal Care Aide (PCA).
(print client name)

______ I am a professional PCA

______ I am a family member acting in the capacity of a PCA

PCA Signature ________________________________ Date ________________________

******* ***Office Use Only*** *******

Date Received ________________________ ID card Mailed _________________

________ Approved ________ Denied Dispatcher _____________________

By _________________________________

Revised 05/2016