Reduced Fare Program Application

Persons With a Disability

Bay Area Transportation Authority
Reduced Fare Program
115 Hall Street
Traverse City, MI 49684
231-941-2324, option #3

BATA REDUCED FARE PROGRAM APPLICATION FOR PERSONS WITH A DISABILITY

A BATA Reduced Fare Card entitles the bearer to a reduced fare on all BATA routes provided by the Bay Area Transportation Authority transit service.

APPLICANT INSTRUCTIONS

To receive a BATA Reduced Fare Card, applicants are required to complete all information in APPLICANT SECTION 1. After you have completed SECTION 1 of this application and completed the HIPAA form, forward the entire application to a **Licensed Physician** for completion of PHYSICIAN SECTION 2. The physician is required to complete all information and return application directly to BATA for processing. If the applicant is a Medicare Cardholder, a copy of the Medicare Card and of a valid photo ID may be sent with the completed SECTION 1 of this application to qualify for a BATA Reduced Fare Card. In this case, PHYSICIAN SECTION 2 will not need to be completed unless a P.C.A. (personal care attendant) is required.

PHYSICIAN INSTRUCTIONS

The applicant has completed SECTION 1 and forwarded the application to you for completion of PHYSICIAN SECTION 2. Please complete all information, including licensing certification. BATA will not hold you liable in any way as a result of furnishing your certification. Please return entire application directly to:

BATA
Reduced Fare Program
115 Hall Street
Traverse City, MI 49684

The BATA Reduced Fare Office is open Monday – Friday 5:30am – 7:00pm
Saturday and Sunday 9:00am – 2:00pm
To contact the office, please call 231-941-2324, option #3.

Please allow BATA 7-14 days for processing after receipt of application from the physician. We will notify you upon your acceptance of eligibility and will provide you with instructions on how to obtain your BATA Reduced Fare Card. The applicant is required to come to our Hall Street Transfer Station to obtain a photo ID card.

Please have your photo ID with you at the time of card processing.

GENERAL PROVISIONS FOR ELIGIBILITY CRITERIA

- The Eligibility Criteria is based on Physician's Certification for the determination of a disability for the BATA Reduced Fare Program.
- A Person with a Disability may also be eligible if they are a Medicare Card Holder.
- Reduced Fare Cards issued for persons with a disability are valid until expiration date shown on card.
- BATA reserves the right to verify the application by contacting persons completing the forms.
- Any fees charged for the completion of the Physician Certification are not the responsibility of BATA.
- A completed HIPAA Privacy Authorization is included with this application and must be completed and returned with the application.
- Certification forms will be confidential records and kept on file at BATA.
- The criteria of eligibility for this application is in accordance with the Americans with Disabilities Act definition that a person with a disability means any person who (a) has a physical or mental impairment that substantially limits one or more major life activities, (b) has a record of such impairment, or (c) is regarded as having such an impairment.

APPLICANT SECTION 1

PLEASE PRINT IN INK

Name ____

Street Address ____

City/State/Zip Code ____

County ____

Telephone Number ___________________ Social Security Number XXX-XX-_____________

Sex Male ( ) Female ( ) Date of Birth ____________________________
mm/dd/yy

Do you use a mobility aid? Yes ( ) No ( )

If yes, please explain type and method used:

Applicant's Signature _______________________________ Date ______________________

If this application has been completed by someone other than applicant, please provide the information below:

Name___________________________________ Telephone Number______________________

Relationship to Applicant ____________________________________

First time applicants will not be charged for the Reduced Fare Card. Any cards lost or damaged are subject to a $5.00 replacement fee.

I understand that BATA has the authority to revoke my Reduced Fare Card if I misuse the card or damage transit agency property. I agree to obey all transit rules and regulations. I hereby certify that the information provided on this application is true and correct.

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PHYSICIAN CERTIFICATION SECTION 2 (To be completed by licensed physician only)

PLEASE PRINT IN INK

Physician's Name ____

Office Street Address ____

City/State/Zip Code ____

County ________________________ Office Telephone Number ______________________

Physician, please complete questions on this page referring to Applicant listed in Section 1.

PHYSICIAN CERTIFICATION SECTION 2 (Continued)

Does the Applicant have a disability? Yes ( ) No ( )

If Yes, please explain and continue completing Section 2:

Identify the physical, physiological, mental or psychological disorder or condition:

Identify the major life activity limited by the above disorder or condition:

Is the disability for the above applicant Permanent ( ) or Temporary ( )

The estimated Temporary period is from _____ to _____
mm/dd/yy mm/dd/yy

If disability is Permanent, do you determine that this is an irreversible disability? Yes ( ) No ( )

Please explain:

Does this person's disability require that he/she use a personal care attendant (PCA) in order to use public transportation? Yes ( ) No ( )

Physician Licensing Identification _____

Physician's Signature _____ Date _____

I hereby certify that the information provided on this application is true and correct.

For Office Use Only
Date application received
Approval Yes ( ) No ( )
Date approved
Card Number
Expiration Date
Issued by

HIPAA Privacy Authorization

For Disclosure of Protected Health Information
Relevant to BATA Reduced Fare Program

Patient's Name: _____ SSN(last 4 digits): XXX-XX-_____ DOB: _____
Address: _____

1. I make this Authorization for the purpose of supplying information needed for the BATA Reduced Fare Program.

2. This Authorization is directed to and applies to protected health information maintained by:

_____
_____ (physicians name and address)
_____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, to release the medical information necessary to respond to the Physician's Certification questions on the Application for a Person with a Disability form submitted with this Authorization. I understand that medical information may include information, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health Rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.

4. This information is to be released to:

BATA
Reduced Fare Program
115 Hall Street
Traverse City, MI 49684

5. I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

6. This Authorization shall be in force and in effect until I am no longer a part of the BATA Reduced Fare Program unless specified otherwise.

7. I understand that I have the right to revoke this Authorization at any time. I understand that, if I revoke this Authorization, I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

8. A copy of this Authorization is as valid as the original.

<u>All Pertinent Sections Of This Form Must Be Completed Before Signing</u>

_____ Dated: _____
Signature of Patient or Personal Representative/Guardian

_____
Print Name of Patient or Personal Representative/Guardian
(along with Description of Personal Representative's Authority)