



Reduced Fare Application

Section 1 (to be filled out by applicant)

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

I hereby authorize for release of my health information to complete this application. I understand the information provided in this application is not confidential and is open to Department of Transportation and Federal Transit Administration authorized officials for compliance reviews.

Applicant's Signature _____ Date _____

Section 2 (to be filled out by physician or licensed health care provider)

Individuals with disabilities can be certified for the reduced fare program if they have one or more of the following:

- Check all that apply:
- Receiving Medicare/Supplemental Security Income benefits
 - Ambulatory disability
 - Hearing impairment
 - Mental impairment
 - Legally blind

State nature of disability: _____

The limitation is (check one) Permanent Temporary

If temporary, please indicate expiration date _____

Print Physician/Certifier _____

Physician/Certifier Signature _____ Date _____

Address _____ Phone _____

Return Completed Application to: Stevens Point Transit
2700 Week St
Stevens Point, WI 54482

If determined eligible for reduced fare transportation, you will receive a reduced fare card. The card can only be used by the person to whom it was issued.