

JONESBORO ECONOMICAL TRANSPORTATION SYSTEM

Fixed Route Disabled Discount Card Application

The information obtained in this certification process will only be used by the Jonesboro Economical Transportation System (JETS). Information will only be shared with other transit providers, upon request of the applicant, to facilitate travel in those areas. The information will not be provided to any other person or agency.

All questions must be answered. Incomplete applications will be returned. If you have any questions or need assistance in completing this application, please call JETS at (870) 935-5387.

APPLICATION MAY BE RETURNED IN PERSON OR BY MAIL TO:

JETS
Attention: Discount Card Application
110 S. Gee Street
Jonesboro, Arkansas 72401

NOTE: *The Disabled Discount Card is for **fixed routes only**. This discount card cannot be used for paratransit services provided by JETS. JETS bus drivers reserve the right to request a photo ID upon boarding for identity verification. If a photo ID is not presented upon request the driver reserves the right to not allow the passenger to receive the discount fare rate.*

Once your application has been approved, you will receive a Disabled Discount Card within 10 business days. This card is to be presented to the bus driver to ensure you receive the discount fare rate. If you do not have your card present upon boarding the driver is not obligated to allow the discount fare rate.

Applicant Name: _____ Date: _____

FOR OFFICE USE ONLY – DO NOT WRITE IN SPACE BELOW

New Applicant: Recertification: Date Received: _____

Reviewed by: _____ Date: _____

Approved: Denied: Recertification Date: _____

PCA: Yes No PCA Name: _____

SECTION A – Customer Registration

PLEASE PRINT

Last Name: _____ First Name: _____

Street Address: _____ Apt #: _____

Building Complex or Name: _____

City: _____ State: _____ Zip Code: _____

Mailing Address if different: _____

Telephone Number: _____ Message Number: _____

Date of Birth: _____ Age: _____ Gender: Female Male

EMERGENCY CONTACT: (DO NOT LEAVE THIS SECTION BLANK)

Name: _____ Relationship: _____

Telephone Number: _____ Alternate Number: _____

SECTION B – Statement of Disability

1. What types of disabilities do you have?

_____ Physical disability	_____ Visual impairment
_____ Developmental disability	_____ Mental disability
_____ Cognitive disability	_____ Other

If other, please explain in detail: _____

2. Is the disability described above temporary or permanent?

_____ Temporary, I expect it to last for another _____ months.
_____ Permanent
_____ I do not know

3. Please indicate below if you use any of the following mobility aids or equipment.

- | | |
|---|--------------------------|
| _____ Manual wheelchair | _____ Powered wheelchair |
| _____ Powered scooter | _____ Long white cane |
| _____ Leg braces | _____ Walker |
| _____ Cane | _____ Crutches |
| _____ Service animal (describe) _____ | |
| _____ Other (describe) _____ | |
| _____ I do not use any of the above aids or equipment | |

NOTE: DUE TO SIZE AND WEIGHT LIMITATIONS ON THE BUS LIFTS, IF YOUR WHEELCHAIR OR SCOOTER IS LONGER THAN 48 INCHES, WIDER THAN 32 INCHES, OR IF THE TOTAL WEIGHT (INCLUDING THE WHEELCHAIR) IS MORE THAN 600 POUNDS WE MAY NOT BE ABLE TO ACCOMMODATE YOUR NEEDS.

4. Can you follow written or verbal instructions? _____

5. Are you able to use a telephone to access transportation information? _____

6. What are the effects of your disability? Explanation is required.

7. Do you require a Personal Care Attendant (PCA) when you travel using the transit? (A PCA is an individual provided by the applicant to assist the passenger).

Yes: _____ No: _____

SECTION D – Health Care Professional

The information provided by the customer on this application is true to the best of my knowledge.

There is information provided by the customer on this application that is NOT true to the best of my knowledge.

A. Has the applicant been diagnosed with a physical, mental, cognitive, or other disability?

Yes No

Diagnosis & onset: _____

ICD – 9 codes: _____

DSM – IV codes: _____

OS – visual acuity & field: _____

OD – visual acuity & field: _____

B. The applicant's disability is: Permanent Temporary
If temporary, until when? _____

Health Care Professional Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Agency: _____

License Number: _____

Profession:

- | | | |
|---|---|--|
| <input type="radio"/> Licensed Physician | <input type="radio"/> Licensed Optometrist | <input type="radio"/> Registered Occupational Therapist |
| <input type="radio"/> Licensed Physical Therapist | <input type="radio"/> Other KAT approved professional | <input type="radio"/> Certified Speech Pathologist |
| <input type="radio"/> Certified Rehabilitation Specialist | <input type="radio"/> Certified Audiologist | <input type="radio"/> Independent Living Specialist |
| <input type="radio"/> Licensed Social Worker | <input type="radio"/> Certified Psychologist | <input type="radio"/> Certified Health Care Professional |
| <input type="radio"/> Licensed Podiatrist | <input type="radio"/> Nurse (LPN or RN) | |

Health Care Professional Signature

Date

APPLICANT'S CERTIFICATION

I understand the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this application is true and correct. I understand any false information will result in denial of eligibility to receive the disabled discount fare rate.

Applicant's Signature: _____ Date: _____

If this application was completed by someone other than the applicant, please complete this section:

Name: _____ **Contact Number:** _____
(PLEASE PRINT)

Signature: _____ **Date:** _____

I certify the information in this application is true and correct to my knowledge. I understand any false information provided will result in the denial of eligibility for the applicant to receive the disabled discount fare rate.