Application For:
REDUCED FARE PROGRAM
(Fixed Route)

FULL FORM

Use this form if you have a disability and do not have a Medicare Card. If you are applying based on age or you have a Medicare Card, complete the SHORT FORM Application.

Part A and Part B must be submitted together in order to be processed. Any applications received that are not complete will be returned to the applicant.

DART First State reserves the right to verify Certification Forms by contacting persons completing the forms.

Any fees charged for the completion of Certification Forms are not the responsibility of DART First State.

Certification Forms are confidential records and kept on file at DART First State during the period of eligibility.

Once your application has been received and all information verified, you will be notified of your approval or denial. You will be required to come in to one of our offices and have a photo taken. Please bring another photo ID with you to verify your identity. Photos can be taken at the following locations:

Monday through Friday
8:00 am – 4:30 pm

Delaware Transit Corporation
900 Public Safety Blvd
Dover, DE

Delaware Transit Corporation
119 Lower Beech St
Wilmington, DE

Arrangements are also available at other sites upon request by appointment.

FOR QUESTIONS CALL:	**MAIL OR FAX APPLICATION TO:**
DART First State **Eligibility Section** **1-800-652-3278, Option 4**	DART First State Eligibility Section 900 Public Safety Blvd Dover, DE 19901 **FAX**: 302-760-2932 If application is faxed, do not send original

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Application For:
REDUCED FARE PROGRAM
(Fixed Route)

FULL FORM

Use this form if you have a disability, and do not have a Medicare Card. All information must be provided in order to process your application.

PART A:
TO BE COMPLETED BY APPLICANT

Name _____
(Last) (First) (M.I.)

Address _____
(Street) (Apt.)

_____
(Name of Development, Apartment Complex, etc.)

_____
(City) (County) (State) (Zip)

Sex: ☐ Male ☐ Female Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____ (Minimum – Last 4 digits required)

Phone Number _____ (where you can be reached Mon-Fri 8:00 am – 4:30 pm)

Signature _____ Date_____

FOR QUESTIONS CALL:	**MAIL OR FAX APPLICATION TO:**
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For office use only: [ ] Approved [ ] Denied By_____ Date_____

Trapeze ID #_____ Picture on File [ ] Yes [ ] No

Notification Mailed Date: By_____ Date_____

Revised Dec 2018

PART B Name of Applicant: _____

PROFESSIONAL CERTIFICATION

Name: _____ Phone: _____

Office Address: _____
(Street)

_____
(City) (State) (Zip)

Licensing Identification: _____

Signature: _____

To be completed by medical professional

1. Impairment or disability is considered:
   ( ) Permanent ( ) Temporary, estimated period of disability from _____ to _____
   (Date) (Date)

2. ( ) Non-Ambulatory Disabled (individuals that us a wheelchair as a mobility aid)
   Any person whose incapacity or disability will not allow that person to walk, even with the assistance of devices, but with or without the assistance of an attendant, has the personal mobility and independence in a wheelchair that use of appropriate public transportation services is a reasonable expectation. NOTE: All DTC buses are ADA compliant and able to accommodate mobility aids up to 55" long, 33.5" wide, and a total combined person and device weight of 800 lbs.

3. ( ) Semi-Ambulatory (individuals that use mobility aids other than a wheelchair on a regular basis) Any person whose incapacity or disability will not allow that person to walk without the assistance of walkers, rollators, crutches, canes, braces, prosthetic limbs, or other such adaptive devices, and for whom use of appropriate public transportation services is a reasonable expectation.
   Type of mobility aid(s) used: _____
   MUST CHECK DISABILITY IN QUESTION 5 OR APPLICATION WILL BE CONSIDERED INCOMPLETE

4. ( ) Ambulatory (individuals that are not dependent on a mobility aid)
   Any person whose disability relates to a degree of visual, audio, physiological, mental or psychological disability or impairment as specified below, and for whom private personal transportation poses an unreasonable difficulty or danger.
   MUST CHECK DISABILITY IN QUESTION 5 OR APPLICATION WILL BE CONSIDERED INCOMPLETE

5. THIS SECTION MUST BE COMPLETED IF 3 OR 4 ABOVE WAS CHECKED.
   ( ) Cerebrovascular accident (CVA – stroke)
   ( ) Pulmonary/Cardiac disability
   ( ) Sight disability – Those persons whose vision in the better eye after correction is 20/200 or less; and those persons whose visual field is contracted (commonly known as tunnel vision) to 10 degrees or less from a point of fixation, or so the widest diameter subtends an angle no greater than 20 degrees.
   ( ) Hearing impairment – Loss is 90 dba or greater in the 500, 1000, 2000 Hz ranges.
   ( ) Faulty coordination - from brain, spinal, peripheral nerve injury, or arthritic condition
   ( ) Epilepsy – petit and grand mal or convulsive seizures
   ( ) Autism
   ( ) Cerebral Palsy
   ( ) Intellectual Disability (a state of significant subnormal intellectual development with reduction of social competence in a minor or adult person)
   ( ) Mental Illness (a mental disease to such extent that a person so afflicted requires care and treatment for their own welfare or the welfare of others in the community)
   ( ) Other – Please specify the disability that impairs mobility.
   Details of semi-ambulatory or ambulatory disability: _____
   _____