

**St. Mary's Transit System (STS)
Paratransit Service, Disability Discount and Senior Discount Eligibility
Application Form**

APPLICATION INSTRUCTIONS

This Application is intended to assist in the mobility and independence of persons with disabilities and senior citizens who have transportation needs. There are **three (3) basic assistance programs** offered as a part of this Application. Please check one of the boxes below to indicate which program you are applying for to facilitate our review of your request. All forms required below must be completed and accurate.

Paratransit
Service



Would you like to apply for Paratransit Transportation?

If you have a disability that prevents you from utilizing the public STS fixed transit services and you need Door-to-Door service, please check this box and **fill out Sections 1-3 (Section 4 is optional, if qualifying by a healthcare professional this section can be used for this purpose).**

Once approved by our office, paratransit transportation services will be provided through the Transit System's ADA or SSTAP programs.

Disability
Discount



Would you like to apply for a Disability Discount Fare Card?

If you have a disability that does not prevent you from utilizing the public STS fixed transit services, please check this box and **fill out Sections 1 and 2 (Section 4 is optional, if qualifying by a healthcare professional this section can be used for this purpose).**

A Disability Discount Fare Card will entitle the card bearer to a discounted fare for public transportation.

Senior
Discount



Would you like to apply for a Senior Discount Fare Card?

If you are age 60 and above and utilize the public STS fixed transit routes, and you are interested in receiving discounted fares, please check this box and **fill out Section 1 only** of the Application Form.

To obtain a Senior Discount Card proof of age (i.e. identification card, birth certificate, etc.) will be required.

For Assistance, Please Contact Us

Ms. Mary Ann Blankenship, Transportation Supervisor (301) 475-4200 x *1123
Fax Completed Application to: (301) 866-6797 or Mail Completed Application to:
P.O. Box 409 California, MD 20619

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Paratransit



**SECTION 1
GENERAL INFORMATION**

(Please provide all of the requested information)

Disability
Discount



Senior
Discount



First Name (please print): _____

Last Name (please print): _____

Date of Birth:

Month _____ Day _____ Year _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

County _____

Directions to your home (Only required for Paratransit Requests): _____

Phone # (Daytime): _____ (Evening): _____

Cell Phone # (Optional): _____

Mailing Address (if different than your street address shown above):

City _____ State _____ Zip Code _____

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SECTION 1 (continued)

**EMERGENCY CONTACT INFORMATION
(Optional)**

The following information will only be used in case of emergency. Completion of this Section is optional for all applicants.

Please provide the name and number of a friend or relative to contact in case of an emergency (Optional):

Name _____

Phone (Daytime) _____ (Evening) _____

Address _____ Apt. _____

City _____ State _____ Zip _____ County _____

APPLICANT/REPRESENTATIVE CERTIFICATION (*Required information*)

Completion of this information is required for all applicants.

I certify that the preceding information is correct. I authorize St. Mary's Transit System to use the information provided to arrange transportation services, including sharing my information with drivers, as necessary.

Applicant Signature _____ Date _____

Disclosure: You may elect to prevent your application information from being shared with STS drivers by marking the box below:

I do not wish for my application information to be shared with drivers

*If it is determined that your application information must be shared with drivers and you have indicated otherwise, we maintain the right to do so and you will be notified.

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SECTION 1 (continued)

APPLICANT/REPRESENTATIVE CERTIFICATION (*Required information*)

If this application was completed by someone other than the individual requesting paratransit transportation or a discount fare card, please complete the following information:

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone Number (Daytime) _____ (Evening) _____

Signature: _____ Date _____

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Disability
Discount



SECTION 2:
CERTIFICATION

(Please provide all of the requested information)

This Section is to be completed **ONLY** if you are applying for **Paratransit Transportation or a Discount Disability Fare Card**. If applying for a paratransit service and you have a permanent disability, verification of a permanent disability must be verified through one of the following;

- Current Social Security Supplemental Income verification (SSI or SSDI) ; or
- Veteran's Administration Disability Determination that stipulates there is a permanent disability; or
- Certification by a Health Care Professional that stipulates there is a permanent disability (Section 4 may be used for this purpose); or
- Acknowledged disabled by a different entity. *Please explain in space below for additional information and provide supporting documentation.

Eligibility for a temporary disability will be based on one of the following:

- Veteran's Administration Disability Determination; or
- Temporary Disability Assistance Program (TDAP); or
- Certification by a Health Care Professional (Section 4 may be used for this purpose); or
- Acknowledged disabled by a different entity. *Please explain in space below for additional information and provide supporting documentation.

Disability Duration (Please check \surd one):

- Permanent
- Temporary Until _____

NOTE: Application renewal depends on the duration of the disability. If you are permanently disabled you will not need to reapply.

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SECTION 2 (continued)

*Additional Information Required:

Paratransit Transportation requests please proceed to **Section 3** of this packet. Missing or inaccurate information may cause a delay in response and approval of services.

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**SECTION 3:
TRANSPORTATION SERVICES**

(Please provide all of the requested information)

This Section **must** be completed if you are applying for **Paratransit Transportation** services. Answering the questions completely will help us provide the service that you need.

Please list the Mobility Aids / Equipment that you use (check all that apply):

- N/A
- Manual Wheelchair Electric Wheelchair Cane/Walker
- Powered Scooter Hearing Aid Oxygen
- Service Animal Crutches
- Other _____

Platform lifts may be used for all types of mobility devices as required under ADA; including wheel chairs, walkers, crutches or standees who have difficulty climbing entry steps.

Reasonable accommodations may be made in advance. **STS accepts all wheel chairs and mobility devices.**

Please also take the time to complete the following:

1. Do you require a personal care attendant to travel with you? Yes No
2. Would you be interested in the Travel Training program? The program provides information on how to use STS buses and routes. Yes No

If you mark 'Yes', a member of our STS staff will contact you for additional information.

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Disability
Discount



**SECTION 4:
REQUEST FOR PROFESSIONAL VERIFICATION
(To be completed by a health care professional)**

Dear Health Care Professional:

Please confirm _____ (applicant) ability to use St. Mary's Paratransit / Disability Discount services. Federal law requires that STS provide paratransit service to persons who cannot use fixed-route transit services. The information you provide will allow us to determine the applicant's eligibility for service.

- A person must be unable to use regular public transit due to physical or mental disability; or
- A person with a disability has a specific impairment-related condition, which prevents such individual from traveling to a fixed route boarding location or from a disembarking location; or
- A person with a disability who is capable of using the fixed route service may be qualified for a discount fare.

(*Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular public transit. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this program. False verification could result in travel limitation for persons legitimately qualified to use the program).

Disability Duration (Please check \surd one). Are the applicant's disabilities:

- Permanent
- Temporary Until _____

I hereby certify that the above information provided regarding the applicant is correct. STS will make the final determination on an applicant's eligibility for STS Paratransit service or disability discount fare.

Health Care Professional's Signature: _____ Date: _____

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Return application to

Please ensure the application is completed and signed.

Mail to: St. Mary's County Government
St. Mary's Transit System
P.O. Box 409
California, MD 20619

Email to: maryann.blankenship@stmarysmd.com or Fax to: 301-866-6797

Contact Information

For Questions/Concerns: 301-475-4200 ext. *1120

For Office Use Only

Approval

Approved Denied

Program

ADA SSTAP
 Disability Discount Fare Card
 Senior Discount Fare Card

Disability Duration

Permanent
 Recertification Required

Notes:

Date Received:
Received by:

Approval Date:
Approved by:

Renewal Date:

Entered in Computer (Access and CTS)
Employee Initials _____ Date: _____

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