RTA

REGIONAL TRANSIT AUTHORITY
APPLICATION FOR DISABILITY REDUCED FARE CARD

The information obtained in this certification process will only be used by Regional Transit Authority to determine if applicant is eligible for a reduced fare on our regular bus service due to a disability.
Persons sixty-five (65) years or older need not complete this form; you are eligible for our Senior Citizen reduced fare if you present a valid State ID or Driver's License to RTA Operators. Medicare Card holders do not have to complete this form. Bring Medicare card, Current Award Letter from Social Security verifying your Medicare status and a valid State ID or Driver's License to the ID Center and receive RTA Reduced Fare Card. The information provided on this application is confidential and will not be provided to any person or agency.

Part 1 Completed By Applicant Please Print in Black or Blue Ink

Last Name	First Name	Middle Initial

Street Address (required)	City/State	Zip

Mailing Address (if different from above)	City/State	Zip

Home Telephone	Work Telephone	Social Security Number	Date of Birth
( )	( )		month day year / /

Emergency Contact Person:	Telephone Number	Relationship
	( )	

Do you currently have the RTA Reduced Fare Card? ❑ Yes ❑ No
If yes, Expiration date_____

Do you have the Lift/Dial-A-Ride Card? ❑ Yes ❑ No
If yes, a current card is accepted on the regular buses

Do you have a Medicare Card? (Red, White & Blue Card) ❑ Yes ❑ No
If yes, read information at the top of the application.

I certify that the above information is correct and the Health Care Professional completing part 2 of this form is familiar with my diagnosis and is authorized to provide and release information required completing this certification for Regional Transit Authority's Reduced Fare Card.

_____/_____

Applicant's Signature **Date**

Office Use Only

Date Rec'd.	Contact Date
Eligibility Status	
Expiration Date	

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RTA Part 2 Can ONLY be completed by a physician (MD) licensed in the State of Louisiana certifying in his/her area of normal practice. 2. A licensed optometrist or ophthalmologist for blindness or low vision. 3. A licensed audiologist or otolaryngologist for hearing.

What is applicant's name?_____

What is the applicant's diagnosis? Please avoid medical abbreviations and describe in lay terms what it is.

_____

_____

_____

Has condition adversely affected applicant? ❑ Yes ❑ No
If yes, how?

_____

_____

How long has applicant had this condition?
_____

If applicable, what extremity or area is affected?
_____

If applicable, is condition: _____Mild _____Moderate _____Severe

Is applicant's condition currently managed or controlled with medication? ❑ Yes ❑ No

Is applicant's condition permanent? ❑ Yes ❑ No

If no, expected duration _____

Does applicant use a mobility aid? ❑ Yes ❑ No If yes, what aid? _____

PLEASE PRINT

HEALTH CARE PROFESSIONAL'S NAME & OCCUPATION (please print)		OFFICE TELEPHONE
OFFICE ADDRESS	CITY/STATE	ZIP
SIGNATURE	DATE	LA PROFESSIONAL LICENSE #

PLACE IN ENVELOPE AND MAIL TO:

REGIONAL TRANSIT AUTHORITY
ID CENTER
2817 CANAL STREET
NEW ORLEANS, LA 70119