# 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
PO Box 1845
Jonesboro, Arkansas 72403

***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 scooter
_______ Leg braces
_______ Crutches
_______ Service animal (describe)______________________________________________
_______ Other (describe)__________________________________________________
_______ I do not use any of the above aids or equipment

_______ Powered wheelchair
_______ Cane
_______ Walker

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: _______

8. Are you currently receiving Medicaid benefits?
   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:**

- ❍ Licensed Physician
- ❍ Licensed Physical Therapist
- ❍ Certified Rehabilitation Specialist
- ❍ Licensed Social Worker
- ❍ Licensed Podiatrist
- ❍ Licensed Optometrist
- ❍ Other KAT approved professional
- ❍ Certified Audiologist
- ❍ Certified Psychologist
- ❍ Nurse (LPN or RN)
- ❍ Registered Occupational Therapist
- ❍ Certified Speech Pathologyist
- ❍ Independent Living Specialist
- ❍ Certified Health Care Professional

________________________________________ ___________________________________

**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.***