



City of Asheville
Discounted Bus Pass Application
for Americans with Disabilities
828.253.5691 • iride@ashevillenc.gov

IMPORTANT: Bring this completed document (include professionals verifying document) to the Transit Station at 49 Coxe Avenue, Asheville, NC 28801 along with identification (ex. government issued I.D. or see acceptable identification listed in Guidelines), your photo will be taken then you will be issued a Discount Pass Pass. If you qualify for a discount for any reason other than a disability, please consult the **Discounted Bus Pass Guidelines** before using this form. If your most limiting condition prevents you from riding the ART, please consider reviewing the **Paratransit Guidelines** and services that may be available, due to your condition.

PART 1 Applicant Information

Name: _____ Birth Date: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Circle whether your condition is permanent or short-term (6 months or less).

PART 2 Required Verifying Document

In order to be eligible for the discount, **you must** submit one of the below verifying documents alongside this application. You can attach the document to your application for processing, or e-mail it to iride@ashevillenc.gov. Documentation that does not fit these requirements may be accepted, but ART staff may follow-up by phone or e-mail before final approval is determined (in which case a 30-day temporary pass may be issued).

- 1) A form from the following service providers can be submitted to verify your eligibility (**check one**):
Social Security Administration, verification letter showing Social Security Disability Insurance (SSDI)
Supplemental Security Income (SSI) with TPQY or Notice of Award letter indicating that you are disabled and have received benefits within the last 12 months.
- 2) The following medical and social service providers can provide either a **completed standard letter (see back side) or a letter on office letterhead**, signed by the professional, verifying your eligibility. The document only needs to state your most limiting condition, whether it is permanent or more short term (6-months).
 - Physician, Psychiatrist, Osteopath, Podiatrist, Optometrist, Audiologist, Otolaryngologist, Certified Physical Therapist, Mental health or behavioral service/counseling provider, Community health center, HIV/AIDS services, rehabilitation clinic or Department of Veterans Affairs.

PART 3 Signature

I certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any falsification of information on this form may lead to disqualification for discounted bus service. I authorize the professional completing the verification statement to release to ART any protected information about my disability in order to verify my eligibility for discounted bus fare.

Applicant signature: _____



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Note: This form is to be completed by the following medical or social service providers, so that the professional can certify the applicant/patient disability is covered under the Americans with Disability Act of 1990, as amended. If the applicant requests that you return this form to them, please return it to them in an official, sealed envelope. Otherwise, you can submit it directly to ART at the physical or email address found above. The following professionals can complete either this standard letter or a letter on office letterhead, signed by the professional, verifying applicant’s eligibility.

- Physician, Psychiatrist, Osteopath, Podiatrist, Optometrist, Audiologist, Otolaryngologist, Certified Physical Therapist, Mental health or behavioral service/counseling provider, Community health center, HIV/AIDS services, rehabilitation clinic or Department of Veterans Affairs.

Applicant Name: _____ Applicant DOB: _____

Description of applicant’s most limiting condition(s) as it relates to their mobility: _____

Is the applicant’s condition **permanent** or **short-term (6- months)**? If short-term, give the expected duration.

Certifying Professional’s Information

Print Name: _____ Job Title: _____

Signature: _____

Name of Organization/Office: _____

Office Address: _____

Phone: _____ Email: _____

Office Use Only: Employee last name: _____ Discount Card # _____

Circle one: APPROVED (PERMANENT) APPROVED (6-months) 30-DAY (TEMP) DENIED

Documentation used: SSDI SSI Standard Letter Doctor letter on letterhead