Bay Area Transportation Authority

BATA REDUCED FARE PROGRAM APPLICATION
FOR PERSONS WITH A DISABILITY
Revised January 2024

A BATA Reduced Fare Card entitles the bearer to a reduced fare of 50% on all BATA services provided in Grand Traverse and Leelanau counties by the Bay Area Transportation Authority.

APPLICANT INSTRUCTIONS
To apply for a BATA Reduced Fare Card, applicants with a disability must:

1. Complete the required **HIPAA form**
2. Complete all information in **SECTION 1**
3. Deliver the entire application to a Licensed Health Care Professional, Case Manager, Social Worker, or School Counselor for completion of **SECTION 2.** A ***Social Security Benefit Verification Letter*** that clearly identifies the bearer as being disabled or a separate document on letterhead from a healthcare office/social worker/school can be submitted in lieu of Section 2.
4. Please mail, email, fax, or hand deliver the completed application directly to:

BATA Reduced Fare Program
115 Hall Street
Traverse City, MI 49684
info@bata.net
fax: (231) 947-1394

Section 2 Instructions for Health Care/Social Worker/School Professionals:
The applicant has completed the HIPAA form and SECTION 1 and forwarded the application to you for completion of SECTION 2. Please complete all information, including licensing certification, and return it to the applicant. BATA will not hold you liable in any way as a result of furnishing your certification.

Once received, BATA will process a hand-delivered completed application as time allows that day, or a mailed/emailed application within 5-7 days. If approved, BATA will notify the applicant of next steps which will include a visit to our Hall Street Transfer Station to obtain a Reduced Fare photo ID card. If not approved, BATA will notify the applicant with the reason for denial and information as to our appeals process if needed.

BATA REDUCED FARE PROGRAM APPLICATION
FOR PERSONS WITH A DISABILITY

General Provisions

- Eligibility for the Reduced Fare Program is in accordance with the Americans with Disabilities Act definition that a person with a disability means any person who (a) has a physical or mental impairment that substantially limits one or more major life activities, (b) has a record of such impairment, or (c) is regarded as having such an impairment.
- BATA reserves the right to verify the application by contacting persons completing the forms.
- Reduced fare eligibility is at the discretion of BATA certifying staff. Exclusions include those whose sole disability is a result of drug and/or alcohol impairment, obesity, or pregnancy. If you have questions regarding this policy, please contact the Reduced Fare Program at 231-941-2324.
- Reduced Fare Cards issued for persons with a disability are valid until expiration date shown on the photo ID card.
- BATA is not responsible for fees incurred by the applicant for the completion of the Licensed Health Care Professional Certification form.
- Application forms are confidential records and will be held on file at BATA.

HIPAA Privacy Authorization for Disclosure of Protected Health Care Information Relevant to BATA Reduced Fare Program

Patient's Name: _____SSN (last 4 digits): XXX-XX-____ DOB: ___/___/___

Address: _____

1. I make this Authorization for the purpose of supplying information needed for the BATA Reduced Fare Program.
2. This Authorization is directed to and applies to protected health care information maintained by:

Health Care Professional Name and Address: _____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, to release the medical information necessary to respond to the Health Care Professional's Certification questions on the Application for a Person with a Disability form submitted with this Authorization. I understand that medical information may include information, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, defined by Michigan Department of Public Health Rule, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.
4. This information is to be released to: BATA - Reduced Fare Program; 115 Hall Street, Traverse City, MI 49684
5. I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.
6. This Authorization shall be in force and in effect until I am no longer a part of the BATA Reduced Fare Program unless specified otherwise.
7. I understand that I have the right to revoke this Authorization at any time. I understand that, if I revoke this Authorization, I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
8. A copy of this Authorization is as valid as the original.

All Sections of This Form Must Be Completed Before Signing

_____ ____/_____/ 20_____
Signature of Patient or Personal Representative/Guardian Date

_____
Print Name of Patient or Personal Representative/Guardian
(along with Description of Personal Representative's Authority)

SECTION 1 – Revised January 2024
To be completed by the <u>Program Applicant/Rider</u>

PLEASE TYPE OR PRINT IN INK

Name _____

Street Address _____

City/State/Zip Code _____

County _____

Telephone Number _____ email: _____

Social Security Number XXX-XX- ___ ___ ___ ___

Sex: Male ( ) Female ( ) Decline ( ) Date of Birth _____
mm/dd/yyyy

Do you use a mobility aid? Yes ( ) No ( )
If yes, please explain type and method used: _____

_____

First time applicants will not be charged for the Reduced Fare Photo ID card. Any cards lost or damaged are subject to a $5.00 replacement fee.

I understand that BATA has the authority to revoke my Reduced Fare Card if I misuse the card or damage transit agency property. I agree to abide by all BATA policies (found on the BATA website or paper copy by request). I hereby certify that the information provided on this application is true and correct.

Applicant's Signature _____ Date _____

If this application has been completed by someone other than applicant, please provide the information below:

Name _____ Telephone: _____

Email: _____

Relationship to Applicant _____

SECTION 2 - REVISED January 2024 (Please type or print in ink)

To be completed by Licensed Health Care Professional, Case Manager, Social Worker, or School Counselor (A Social Security Benefit Verification Letter that clearly identifies the bearer as being disabled or a separate document on letterhead that includes the information below is acceptable in lieu of this page. BATA may check ID)

Professional's Name & email _____

Facility Name & Phone # Traverse Health Clinic 231-935-0799

Office Street Address 1719 S Garfield Ave

City/State/Zip Code Traverse City MI 49686 County Grand Traverse

Does the applicant have a disability? Yes ( ) No ( ) If Yes, please explain:

Identify the physical, physiological, mental, or psychological disorder or condition:

Identify the major life activity limited by the above disorder or condition:

The disability for the above applicant is: Permanent ( ) / is: Temporary ( )

If temporary, what is the estimated end date of disability: _____ / _____/ 20____

If permanent, please explain:

If a **Personal Care Attendant (PCA)** or traveling companion is recommended, please explain:

I hereby certify that the information provided on this application is true and correct:

Signature _____ Date _____

Health Care Professional Licensing/Certification Identification _____

For Office Use Only
Date application received _____
Date approved / denied _____
Expiration Date_____

Approval Yes ( ) No ( )
Card Number _____
Issued by_____