Detroit Department of Transportation Reduced Fare Card Application

The Detroit Department of Transportation (DDOT) Reduced Fare program enables eligible riders to ride DDOT's fixed route buses at a reduced rate of 50 cents per trip.

Am I eligible?

Applicants who meet one or more of the following criteria are eligible for reduced fare:

- Senior: Individuals 65 years of age or older.
- Medicare card holder.*
- Individuals with a disability: Includes any injury or disability that physically or cognitively limits mobility independence. **

* Eligible to receive the reduced fare by showing a Medicare card to the bus operator.

** Must complete a Professional Verification Form by a health care professional.

How do I obtain a Reduced Fare Card?

All applicants must complete a Reduced Fare application. Applicants must provide a copy of a valid photo ID (driver's license, state ID, Detroit ID, or passport).

Note: Legally blind persons with documented proof as "legally blind," as evidenced by a valid state ID, are automatically approved without a Professional Verification Form. Include a copy of your valid state ID noting "legally blind" with your application.

Applicants deemed ineligible shall be mailed notification of the reason for the decision.

Please return completed forms and required documentation to:

Detroit Department of Transportation
In-Person Applications
Rosa Parks Transit Center
1310 Cass Ave.
Detroit, MI 48226

Mail Only Applications
Detroit Department of Transportation
ATTN: Reduced Fares
1301 E. Warren Ave. Room 106
Detroit, MI 48207 TDD/TTY Hearing-Impaired 7-1-1

DDOT Reduced Fare Card Application

First name: M.I.:

Last name:

Address: Apartment/unit number:

City: Zip code:

Phone number:

Email:

Date of birth:

Do you require a personal care attendant (or aide)? ☐ Yes ☐ No

I meet one of the following criteria: ☐ Medicare card holder ☐ Senior

☐ Individual with a disability

SUPPORTING DOCUMENTS

Please provide the following materials with your application.

Senior (65 years of age or older)	Copy of a valid photo ID (driver's license, state ID, Detroit ID, or passport).
Medicare cardholder	Copy of a Medicare card and a valid photo ID (driver's license, state ID, Detroit ID, or passport).
Mobility Disabled	Copy of a valid photo ID (driver's license, state ID, Detroit ID, or passport) and a Professional Verification Form completed by a health care professional.

DDOT Reduced Fare Card Application

EMERGENCY CONTACT

First name: M.I.:

Last name:

Phone number:

Applicant Acknowledgement

I attest that the above information is true and correct to the best of my knowledge. I also understand any of the above information found to have been intentionally falsified will lead to immediate termination and is reported directly to the Detroit Department of Transportation.

Signature: Date:

Note: Applications not accompanied by a copy of valid identification, phone number, address, and a completed Professional Verification Form will be denied.

Note: Reduced Fare passes are to be used by eligible riders approved and verified by the Office of the Chief Financial Officer (OCFO) and DDOT. Riders are required to apply with the required supporting documentation. Riders who purchase Reduced Fare passes are subject to a maximum number of passes noted in the table below:

Description	Price	Max (In A Period)	Timeout (Days)
4-Hour Regional Pass Reduced	**$0.50**	**2**	**1**
24-Hour Regional Pass Reduced	**$2.00**	**1**	**1**
7 Day DDOT Pass Reduced	**$8.00**	**1**	**3**
7 Day Regional Pass Reduced	**$10.00**	**1**	**3**
31 Day DDOT Pass Reduced	**$17.00**	**1**	**21**
31 Day Regional Pass Reduced	**$29.00**	**1**	**21**

DDOT Reduced Fare Card Professional Certification Form

This section must be completed by a licensed health care professional.

The applicant requests certification as an individual with a disability for issuance of a DDOT Reduced Fare Card to access transit at a reduced rate. Eligibility is as follows per the Federal Transit Administration (FTA):

"Individuals who by reason of illness, injury, age, congenital malfunction or other permanent or temporary incapacity or disability, including those who are non-ambulatory wheelchair bound and those with semi-ambulatory capabilities, are unable without special facilities or special planning or design to utilize mass transportation facilities and services as effectively as persons who are not so affected."

Please mark all conditions that affect the applicant's ability to use mass transit.

- ☐ **Neurological disorder** that interferes with coordination, strength or endurance such as polio, cerebral palsy, multiple sclerosis, paralysis or frequent uncontrolled seizures and special sensory disorders such as **Legal Blindness** or 50% bilateral loss of hearing.
- ☐ **Any disability of more than six months** (or 180 days) which requires the use of walkers, crutches, wheelchairs or other mobility devices.
- ☐ **Significant muscular-skeletal impairment** such as muscular dystrophy or severe arthritis.
- ☐ **Cardiovascular, respiratory impairment,** dialysis or cancer treatments which significantly interfere with coordination, endurance or strength.
- ☐ **Significant cognitive impairment.**
- ☐ **One or more missing limbs.**

DDOT Reduced Fare Card Professional Certification Form

It is my opinion that this disability is (check one):

☐ Temporary (expected to last _____ months).

☐ Permanent

PROFESSIONAL CERTIFICATION

Name of health care professional: _____

Professional title/specialty: _____

Agency/office name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____

Michigan license number: _____

Professional Acknowledgement

If any of the statements on this document are false or inaccurate, DDOT shall preclude me from future applicants. I understand that such activities, may subject me to criminal prosecution in accordance with applicable laws of the State.

Signature: _____ Date: _____

Release of Information

Authorization To Obtain Physician or Other Professional Verification

In order to evaluate your request, it may be necessary to contact your physician or other professional to confirm the information you have provided. Please complete the following information.

Profession:

☐ Physician ☐ Health Care Professional ☐ Rehabilitation Professional

Professional's Name: _____

Agency: _____

Office Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____ Office fax: _____

Applicant's Name: _____

Date of Birth: _____

I understand that the purpose of this application is to determine if there are times when I cannot use the public bus service and must therefore use ADA paratransit services. I certify that to the best of my knowledge the information in this application is true and correct. I understand that providing false or misleading information may result in a reevaluation of my eligibility.

☐ I accept the terms listed above.

Click to send form now.