



www.ridethebus.org • 503-861-7433 Option #3

Sunset Empire Transportation District Reduced Fare Pass Application

Instructions

Sunset Empire Transportation District offers discounted monthly passes to anyone that is disabled or has a disability (temporary or permanent), is age 60 years or older, active duty military or Veteran, a student (K-12), a college student, or is low income. To be eligible for this discount you will need to qualify for and receive an

Reduced Fare I.D. Card.

This card will have your name and photograph on the front.

Please complete the attached application to help us determine your eligibility.

Section 1: Applicant

Applicant completes this section of the application. Please note that if applicable, you will be required to provide documentation and or identification to verify your eligibility. We will make and retain a copy of this for our records. If you need this application in an alternative format, please call to request one at 503-861-7433 option 3.

Section 2: Health Care Provider

You may need to ask your Health Care Provider to complete this section of the application to verify your eligibility. If you need assistance getting this application to your healthcare provider, please let us know so we can assist you.

Please return your completed application by mail or fax. You may also bring your application to the Astoria Transit Center located at 900 Marine Drive, Astoria OR. 97103.

Mailing Address:

Sunset Empire Transportation District
900 Marine Drive
Astoria, OR 97103

Fax: 503-325-1606

If you have any questions or need assistance completing this application,
please call our transit center staff at 503-861-7433 option 3.

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SUNSET EMPIRE
TRANSPORTATION
DISTRICT

Reduced Fare Pass Application

900 Marine Drive • Astoria, OR 97103 • 503-861-7433 • www.ridethebus.org

Section 1. Applicant information

Name: _____, _____
Last Name First Name

Mailing Address: _____
Street City State Zip

Date of Birth: _____ Telephone Number: (_____) _____

I am applying for a Sunset Empire Transportation District Reduced Fare Pass ID Card.

This is my first ID card.

Certification of eligibility section (Check only one box below)

- Social Security.** Attach benefit verification to this application
- Senior (60+).** 60 years of age or older. Must present government issued photo ID.
- Veteran.** Attach VA documentation to this application.
- Currently deemed eligible for ADA Paratransit**
- Health care provider certification:** To qualify under this type of eligibility, you must have the **health care provider certification** section on the reverse side completed.
- Student.** Attach a copy of student ID or enrollment confirmation.
- Low Income.** Attach a copy of confirmation of benefits from DHS.

I agree to release the information I am sending to Sunset Empire Transportation District for the purpose of making this application for a Reduced Fare Pass ID card. I certify that the information I provide concerning my application is true and correct. I understand that SETD reserves the right to require additional documentation if necessary. If applying for the Reduced Fare Pass ID card, I agree to abide by the terms of the program and photo ID card. I give my consent for SETD to take and retain a copy of my photo.

Signature of applicant _____ Date _____

FOR INTERNAL USE ONLY

Date received

Reduced Fare Card Number

Staff Initials

Section 2. Health Care Provider certification section: This form is used for individuals with permanent or temporary disabilities.

Patient/applicant release:

I authorize: _____ to verify my disability if requested to do so.
(Name of certified and/or licensed health care provider)

Patient/applicant signature: _____ Date: _____

To be completed by licensed Health Care Provider

Applicant's name: _____

Applicant's date of birth: _____

Health care provider's name: _____

Title: _____

State certification or license #: _____

Telephone number: _____

Email address: _____

Health care facility address: _____

I, _____ hereby certify that I have examined the patient

(Name of certified and/or licensed health care provider)

listed above and it is my opinion that he/she is disabled due to illness, congenital malfunction, or other incapacity that substantially limits one or more major functions.

Disability is:

Permanent

Temporary (defined as impairment lasting not more than 12 months) Duration is _____ months.

I certify that the above is correct and that I am legally certified and/or licensed in my state as a Healthcare Provider.

Signature _____ Date _____

Transit Center staff may contact you for verification.

Completed application and health care provider certification may be mailed to the Transit Center, 900 Marine Drive, Astoria, OR 97103

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