Reduced Fare Application Form

Please complete all applicable sections.

A Health Care Professional must complete the **Professional Certification** section before your application can be processed.

Applicant Information

I confirm that I am a City of Belleville resident residing in Ward 1 ☐ Yes

First name: _____

Last Name: _____

House/911 number: _____ Street name: _____

Apt. or unit #: _____ City: _____ Postal Code: _____

Primary Phone Number: _____

Secondary Phone Number: _____

E-Mail Address: _____

Emergency Contact

Name: _____

Phone Number: _____

Relationship: _____

Mobility Requirements

Transportation Needs: (check all that apply)

☐ Require a mobility aid (e.g. wheelchair, walker, scooter, etc.)
☐ Vision-related limitations affecting independent travel
☐ Cognitive, neurological, or medical condition affecting safe, independent travel
☐ Other Accessibility-related conditions affecting transit use (please specify):
_____

I need to travel with an attendant: ☐ Yes ☐ No

APPLICANT DECLARATION

I hereby certify that to the best of my knowledge, the information given above is correct.

I authorize the release of medical information to the City of Belleville. I consent to the contents of my application and eligibility for specialized transit services discussed with the health care professional that completed part of this application.

Signature of Applicant or Designate: _____

Date: _____

Important

Your application cannot be processed until the Professional Certification section has been completed by an acceptable healthcare professional.

Acceptable health care professionals include:

- Licensed Physician
- Registered Occupational Therapist
- Licensed Physical Therapist
- Registered Nurse
- Certified Psychologist or Psychiatrist
- Licensed Optometrist, Ophthalmologist, or Eye Physician

Applicants who are recipient of Government Sponsored Assistance may substitute a letter from their case worker in lieu of the professional certification form.

Reduced Fare Application - Professional Certification

City of Belleville residents applying to receive a Reduced Transit Fare must provide Professional Certification, which must be completed by a health care professional.

You are being asked by the applicant to provide information regarding his/her ability to use public transit and whether they need a support person to travel with them. The information you provide will allow us to evaluate the request and to provide the appropriate service.

Completing for Applicant:

Applicant's Transportation Needs:

☐ Requires a support person when using public transit.
☐ Requires a mobility aid (e.g., wheelchair, walker, scooter, etc.)
☐ Vision-related limitations affecting independent travel
☐ Cognitive, neurological, or medical condition affecting safe independent travel
☐ Other accessibility-related conditions affecting transit use (please specify):
_____

Additional Comments (optional):

Healthcare Provider Name: _____

Clinic/Organization: _____

Phone Number: _____

Healthcare Professional Signature: _____ **Date:** _____

Please return the completed form to bellevilletransit@belleville.ca or Transit Services, 400 Coleman Street, Belleville, ON K8P 3J4.

Personal information on this form is collected under the authority of the Municipal Freedom of Information and Privacy Protection Act and will be used to assess the individual's qualifications for Reduced Transit Fare and will remain Confidential.