RFTA Select Discount Card Program

This guide provides general information on the program. For additional information, please contact RFTA at 970-384-4957.

What is a Select Discount Card Program?

An eligible person is issued a free **Select Discount Card (SDC)** which is used to purchase bus passes at certain RFTA locations. RFTA offers a 50% fare reduction for **Veterans** and **Persons with Disabilities** when purchasing the passes listed below that can be used on any paid regional commuter RFTA transit route.

RFTA has a variety of passes, choose the RFTA Pass that works best for you.

Eligibility Requirements for New Cards and Expired Cards:

Veterans must provide ***one*** of the following appropriate identification:

- **The DD214, Synopsis of Military Career** – Each person in the U.S. military should have received one of these at the time of discharge, regardless of condition of discharge. This is not a card and few veterans would routinely carry this around; **OR**

- **VA Medical ID** – This is a card, and it comes with an ID photo, but not every veteran would have one. Those associated with the VA clinics in Glenwood Springs or Grand Junction would likely have it on their person.

Persons with Disabilities must provide ***one*** of the following original items as proof of disability dated ***within the last three months***:

- **Medicare Card** – white, red, and blue cards are accepted; **OR**

- **Social Security Disability Insurance** - a current TPQY form or Notice of Award letter which indicates that you are disabled and that you have received benefits within the last twelve months; **OR**

- **Healthcare Provider Statement Form** - (See attached form; form must have been signed and dated by the healthcare provider within the last three months.) Healthcare Professionals, if applicant meets the eligibility criteria, please attach a statement on your professional letterhead noting the name and diagnosis of the applicant and describing in detail how the applicant meets the eligibility criteria.

No other proof of disability will be accepted. No photocopies and faxes will be accepted.

How to Apply:

Bring your appropriate documentation as described above and your photo identification to one of the following RFTA locations:

1. **Finance Department 0076 Industry Way, Carbondale – Mon.-Fri. 9:00 am – 4:00 pm**
2. **Rubey Park Transit Center, E. Durant Avenue, Aspen – Mon.-Fri. 9:00 am – 4:00 pm**
3. **Aspen Maintenance Facility 0051 Service Center Drive, Aspen – Mon.-Fri. 9:00 am – 4:00 pm**
4. **Glenwood Maintenance Facility 2307 Wulfsohn Road, Glenwood Springs – Mon.-Fri. 9:00am – 4:00pm**

RFTA offices are closed on major holidays.

RFTA will accept photo identification issued by a state or federal agency, such as a state driver's license or V.A. card. Photocopies and other forms of photo identification will not be accepted. Please allow 3-5 business days for approval of your eligibility. Upon approval of your eligibility, your SDC will be issued and mailed to you.

How to Receive the Discount:

1. Order your transit card by completing the **SDC Pass Order Form** with your credit card information and emailing it to passorders@rfta.com or faxing it to (970) 963-4943, and your order will be mailed to you within 3 business days along with your receipt; **OR**
2. Present your SDC to the Rubey Park Transit Center at the time of purchase.

Discount cannot be applied at other points of sale, including at RFTA Ticket Vending Machines and third party pass outlets.

Lost Cards or Damaged Cards:

To replace a lost or stolen SDC, please call (970) 384-4957 during normal RFTA business hours. The charge for replacing a lost or stolen SDC is **$10**. Damaged cards will be replaced at no charge; however, the damaged card must be presented and turned in at the time of being reissued.

For additional information:
Contact Sabrina Harris, Finance Department, at 970-384-4957 or e-mail at: sharris@rfta.com

Note: Special Discount Card photos will not be taken on the following days: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Day after Thanksgiving, and Christmas Day.

RFTA SELECT DISCOUNT HEALTHCARE PROVIDER FORM

Applicant Section

Disability Affirmation:

I am disabled as described in the Healthcare Professional Section of this application. I affirm under penalty of perjury that all statements made by me on this application and to the physician or other licensed professional named on the form, upon whose opinion RFTA relies for determination of eligibility status, are true and complete. I understand that all statements made in this application may be subject to investigation and verification, that material misstatement or fraud will disqualify me for the Select Discount Program. I understand that RFTA will rely upon the statements made in this application, whether or not RFTA has investigated the statements contained in this application. RFTA may, at its discretion, waive requirements on a case-by-case basis. I understand that RFTA may discontinue or change its Select Discount Program without notice. I understand that it is a crime to allow anyone else to use my Select Discount Card or for me to continue to use the card if I am no longer disabled as defined by the Select Discount Program.

_____

Print Applicant Name

_____

Signature of Applicant **Date**

Medical Authorization:

I authorize the release of any medical information necessary to process this application.

_____

Signature of Applicant **Date**

_____

Address **City** **Zip Code**

_____ **XXX-XX-**_____

Phone Number **Last four digits of your Social Security Number**

Healthcare Professional Section: (Please type or print in ink.)

Check one: (You must be one of the following types of licensed healthcare professionals in order to complete this form.)

____Physician ____Registered Nurse ____Optometrist Audiologist ____Psychologist ____Psychiatrist ____Occupational Therapist ____Physical Therapist

____Licensed Social Worker or Licensed Special Education Teacher (May complete the Mental Retardation and/or Mental Impairment Section only. In the statement of eligibility, please state your qualifications and basis for making the disability judgment.)

Type of Disability:

I have examined the applicant (fully identified in the Applicant's Section of this application). It is my opinion that he/she is a "disabled person" within the meaning of the terms set forth in this document. The impairment is the following:

Check all that apply:

____Blindness – There is central visual acuity of 20/200 or less in the better eye with the use of correcting lenses. An eye which, accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle of greater than 20 degrees, shall be considered as having central visual acuity of 20/200 or less.

____Hearing Impairment – With hearing aids, hearing is NOT restored to one of the following levels:

____Average hearing threshold sensitivity for air conduction of 90 decibels or greater, and for bone conduction to corresponding maximum levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000, and 2000 Hz.

____Speech discrimination scores of 40% or less in the better ear.

____Ambulatory Disability/Disorder of Gait – From whatever cause, the person is unable to move about without a walker, wheelchair, wheelchair stroller, a crutch, crutches, or a cane at all times. The word "unable" is used in its literal sense. The fact that one of these mechanical aids facilitates movement is not sufficient.

The applicant is incapable of moving about without use of the following aid:

____Wheelchair ____Wheelchair Stroller ____Cane ____Walker ____Crutch (es)

____Other Ambulatory Aid (please describe) _____

_____

_____

____Loss of Both Hands – By reason of amputation or anatomical deformity, the person lacks both hands.

____Epilepsy

____Mental Retardation and/or Mental Impairment – The scores specified below refer to those obtained on the W.A.I.S. and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.

____The person is mentally incapacitated such that he/she is dependent upon others for personal needs (e.g., toileting, eating, dressing, or bathing) AND is unable to follow directions such that the use of standardized measures of intellectual functioning is precluded.

____Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 59 or less.

____Based on a valid verbal, performance, or full-scale IQ test, the person has an IQ of 60 to 70 AND is unable to perform routine repetitive tasks OR has a physical or other mental impairment imposing additional and significant limitation of mobility or gait.

____Serious Mental Illness – The applicant currently meets the criteria for a DSM-IV diagnosis other than (i) alcohol or drug disorders, (ii) developmental disabilities, (iii) dementia or mental disorders due to general medical conditions, except those with predominant psychiatric features, or (iv) social conditions (V-codes): AND experiences substantial impairments in functioning due to the severity of his/her clinical condition. The applicant experiences substantial dysfunction in a number of areas of role performance or is dependent on substantial treatment, rehabilitation, and support services in order to control or maintain function capacity. Further, the person has experienced substantial impairments in functioning due to mental illness for an extended duration.

Expected Duration of Disability:

Temporary (more than three months but less than five years) please indicate anticipated length of disability: _____

_____

Permanent (Card duration 5 years) ____

Statement of Eligibility:

If applicant meets the eligibility criteria, please attach a statement on your professional letterhead noting the name and diagnosis of the applicant and describing in detail how the applicant meets the eligibility criteria. Photocopies and form letters are not acceptable. This statement is required in order to process this application.

_____

Full Name of Healthcare Professional's/Licensed Social Worker or Teacher (Required)
License No.

_____

Address
Suite #

_____

City/ State/ Zip **Telephone Number**
Fax Number

_____

Original Signature (Required) **Date**