11 Riverside Street
Nashua, NH 03062
Phone: 603-880-0100
Fax: 603-821-2042

FOR OFFICE USE ONLY

Staff Signature: _____

Date Eligibility Determination: _____

Approved: 1 year 5 years Lifetime Denied

Reduced Fare/Half Fare Application

Thank you for your interest in the Nashua Transit Systems (NTS) **City Bus service**. Persons who are eligible through this application process pay a reduced fare while traveling on our City Bus system. Persons age 60 and older ride free.

☐ New Application ☐ Renewal Application ☐ Replacement Application

APPLICANT INFORMATION

Name: _____ DOB: _____

Address: _____

Phone (Primary): _____ Phone (Secondary): _____

Email: _____

CERTIFICATION OF ELIGIBILITY (check all that apply) *Medicare was established under Title XVIII of the Social Security Act

Option	Required Materials	Program	Fare
☐ I am a Veteran	Present veteran's ID, DD-214 Form, or an original letter from the VA signed by a veteran's service officer.	Honored Citizen & Reduced Fare	$0.60
☐ I am a Medicare Recipient	Present your red, white and blue *Medicare card and/or your SSI/SSDI card as proof of a disability, if applicable.	Honored Citizen & Reduced Fare/Half Fare	$0.60
☐ I am Disabled	Present your red, white, and blue *Medicare card (if applicable) and/or your SSI/SSDI (SS Disability) card.	Honored Citizen & Reduced Fare/Half Fare	$0.60
☐ I am 60+ years old	Present your state issued ID as proof of age.	Senior Fare	FREE
☐ I DO NOT fit into any of the above options.			

If you fit into one of the above categories, you DO NOT need to complete the Health Care Professional Certification section. However, if you DO NOT fit into one of the above categories, you may still qualify for Reduced Fare/Half Fare. Please complete the Health Care Professional Certification section and submit it with your application.

Patient/Applicant Release:

I authorize: _____ to verify my disability if required to do so by NTS.

Patient/applicant signature: _____ Date: _____

HEALTH CARE PROFESSIONAL CERTIFICATION

This form is for individuals with temporary, long-term or permanent disabilities. This also includes individuals who may need an attendant to ride NTS service.

A certified licensed health care professional must complete this section.

Applicant's Name: _____ Date of Birth: _____

Health care provider's name and Title: _____ Phone: _____

Address: _____

_____

I, _____ hereby certify that I have examined the patient 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 life functions.

Disability is:

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

☐ Long-Term (defined as impairment lasting not more than 5 years).

☐ Permanent (defined as impairment lasting the remainder of the applicant's lifetime).

Please select the applicant's use of a mobility aid, if applicable:

☐ Wheelchair

☐ Walker

☐ Cane

☐ Other: _____

Does the described disability necessitate that the applicant have a Personal Care Attendant (PCA) to ride NTS service?

☐ Yes

☐ No

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: _____

NTS staff may contact you for verification.
Completed application and health care provider certification may be mailed to the NTS Administrative Office, 11 Riverside St. Nashua, NH 03062
603-880-0100 | www.RideBigBlue.com