

**Stateside Access**

**Pass Application**

**download this printable version of the application and mail it to:**

**SRTA**

**700 Pleasant Street, 1st Floor**

**New Bedford, MA 02740**

**If you have any questions please contact us at (508) 997-6767, or at our  
email address: [srtaservice@aol.com](mailto:srtaservice@aol.com).**

**INFORMATION OBTAINED IN THIS CERTIFICATION PROCESS WILL ONLY BE USED BY THE SOUTHEASTERN REGIONAL TRANSIT AUTHORITY FOR DETERMINATION OF ELIGIBILITY FOR REDUCED FARE ON REGULAR FIXED ROUTE SERVICE. THE INFORMATION WILL NOT BE PROVIDED TO ANY OTHER PERSON OR AGENCY.**

**--- PLEASE PRINT ---**

1. Name: \_\_\_\_\_

(last) (first) (middle initial)

2. Address: \_\_\_\_\_

(street) (apt. #)

\_\_\_\_\_  
(city/town) (state) (zip)

3. Mailing Address *(If Different)*

\_\_\_\_\_  
(street) (p.o. box #) (city/town) (state) (zip)

4. Telephone Number: *(home)* \_\_\_\_\_ *(work)* \_\_\_\_\_

5. Date of Birth: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

6. Do you have a Medicare Recipient Identification Card? **Yes / No** \_\_\_\_\_

*(If "Yes" include a copy of the card.)*

\_\_\_\_\_  
***(If you answer "Yes" to the above question, Please provide a copy of your card. You do not have to go any further in this application. )***

***To receive the Transit Discount you may:***

***1. Present both your Medicare Identification Card along with any PHOTO IDENTIFICATION as proof of identity to the driver when you get on the bus.***

***2. Pay the appropriate fare in the farebox.***

***If you have answered "Yes" AND still wish to be issued a SRTA ID, you must: Bring your Medicare Identification Card and proof of identity to the Administrative Offices and a card will be issued for a photo identification.***

***Applications may be mailed or brought directly to: SRTA Administrative Offices, 700 Pleasant Street, Suite #1, New Bedford, MA 02740***

***If you are approved for an Access Pass you will be instructed as to how to get your Photo ID through the mail.***

**Return the application to the Administrative**

**Office so that it may be kept on file.**

**THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT YOU ARE CERTIFIED IN THE APPROPRIATE MANNER AND PROVIDED WITH THE SERVICE THAT YOU ARE ENTITLED.**

9. Do you use any of the following aids to mobility? **(Check all that apply)**

Manual wheelchair \_\_\_\_ Power scooter \_\_\_\_ Powered chair \_\_\_\_

Cane \_\_\_\_ Walker \_\_\_\_ Crutches \_\_\_\_ Braces \_\_\_\_ Aide dog \_\_\_\_

**10. Please answer the following questions:**

Can you travel 1/4 of a mile to a bus stop?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

Can you climb three (3) 12 inch steps?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

Can you deal with unexpected situations or routines?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

Can you follow directions or give requested information?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

Can you travel through crowded terminals or congested areas?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

Can you read and understand informational signs?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

Can you hear instructions given by a Driver?

Yes \_\_\_\_ No \_\_\_\_ If No Why? \_\_\_\_\_

**I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS  
CORRECT.**

**Signed** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

**TO THE APPLICANT:**

**IN ORDER TO ALLOW SRTA TO EVALUATE YOUR REQUEST, PLEASE CONTACT A PHYSICIAN, HEALTH CARE PROFESSIONAL OR OTHER PROFESSIONAL TO CONFIRM THE INFORMATION YOU HAVE PROVIDED. PLEASE HAVE THE FOLLOWING INFORMATION PROVIDED TO THE AUTHORITY. ALL QUESTIONS MUST BE ANSWERED BEFORE A DETERMINATION CAN BE MADE.**

**TO THE CERTIFIER:**

**THE ATTACHED INFORMATION HAS BEEN SUBMITTED TO SRTA BY THE APPLICANT. SRTA ASKS THAT YOU PROVIDE INFORMATION REGARDING HIS/HER DISABILITY AND ITS IMPACT UPON THEIR ABILITY TO UTILIZE OUR TRANSIT SERVICES. A PERSON MUST HAVE AN ACTUAL PHYSICAL OR MENTAL FUNCTIONAL DISABILITY THAT LIMITS ONE OR MORE OF THEIR LIFE ACTIVITIES BUT YET STILL ENABLES THEM TO USE REGULAR ACCESSIBLE PUBLIC TRANSPORTATION. A MEDICAL DIAGNOSIS OF AN ILLNESS OR MEDICAL CONDITION DOES NOT AUTOMATICALLY MAKE THE APPLICANT ELIGIBLE FOR SERVICE. THE INFORMATION THAT YOU PROVIDE WILL ALLOW US TO MAKE AN APPROPRIATE EVALUATION OF THIS REQUEST AND ITS APPLICATION TO SPECIFIC TRIP REQUESTS. THANK YOU FOR YOUR COOPERATION IN THIS MATTER.**

1. Capacity in which you know the applicant:
2. Diagnosis which you believe makes the individual eligible for this program
3. Is the condition temporary? **Yes / No** \_\_\_\_\_ Expected duration: until \_\_\_/\_\_\_/\_\_\_
4. If the person has a disability effecting mobility can the person:  
Travel 1/4 mile to bus stop? Yes \_\_\_\_\_ No \_\_\_\_\_  
Travel 3/4 mile to bus stop? Yes \_\_\_\_\_ No \_\_\_\_\_  
Climb three (3) 12 inch steps? Yes \_\_\_\_\_ No \_\_\_\_\_  
Stand in a moving bus? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Is the person able to:  
Follow verbal directions? Yes \_\_\_\_\_ No \_\_\_\_\_

Hear announcements in terminals or by drivers? Yes \_\_\_\_\_ No \_\_\_\_\_

Read informational signs? Yes \_\_\_\_\_ No \_\_\_\_\_

Give addresses and telephone numbers upon request? Yes \_\_\_\_\_ No \_\_\_\_\_

Recognize landmarks and/or destinations? Yes \_\_\_\_\_ No \_\_\_\_\_

Safely travel through crowded/ unfamiliar places? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Does the client use any of the following aids to mobility? (Check all that apply)

Manual wheelchair \_\_\_\_ Power scooter \_\_\_\_ Powered chair \_\_\_\_

Cane \_\_\_\_ Walker \_\_\_\_ Crutches \_\_\_\_ Braces \_\_\_\_ Aide dog \_\_\_\_

7. If the person has a visual impairment:

Visual acuity with best correction:

Right Eye \_\_\_\_ Left Eye \_\_\_\_ Both Eyes \_\_\_\_

Visual fields:

Right Eye \_\_\_\_ Left Eye \_\_\_\_ Both Eyes \_\_\_\_

8. Is there any other limitations to a life activity which you consider may make the individual eligible for this program that has not been covered in previous question? \_\_\_\_\_

If "Yes" Please explain completely:

\*\*\*\*\*

Certifier's Name (Please Print) : \_\_\_\_\_

Office Address: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

**(NOTE: FAILURE TO ANSWER THESE QUESTIONS MAY DELAY OR JEOPARDIZE THE CERTIFICATION FOR SERVICE.)**

FOR OFFICE USE ONLY:

DATE RECEIVED EXPIRATION DATE

IDENTIFICATION NUMBER:

DATE MAILED

PM5-SRTA-TDAPP - (2/11/04)