JATA
Jackson Area Transportation Authority

August 7, 2018

Recovery Technology
1200 N. West Avenue, Ste 400
Jackson, MI 49202

Dear Director,

Enclosed is a revised ADA Verification Form for Half-Fare Card Authorization.

Please use this form to verify that your client is disabled according to the Federal ADA Regulations. It is important that the person signing the form **Print** their name on the form and include a phone number should we need to contact them.

Please fax the forms to our office at 517-787-6833. We are having some issues with forms being brought in that are being signed by unauthorized persons or by the client themselves. Forms will no longer be available at the Transfer Center. If you are in need of forms please call 517-787-8363.

Also it's important to point out to your client whether the pass is permanent or temporary. Some clients are not aware that their card expires. We do put an expiration date on the card however some clients do not fully understand that the card has an end date.

We want to provide a discount for disabled people in our community and need your help ensuring that the program works properly. Thank you for your cooperation.

Please feel free to contact me if you have any questions or concerns at 517-780-3775.

Sincerely,

Debbie

Debbie Brown-Cederna
Office Manager

ADA VERIFICATION FORM FOR HALF-FARE CARD AUTHORIZATION

Attending Physician or Qualifying Agency:

Please verify that the following patient is under your care and indicate whether the patient does/does not qualify as disabled under the Americans with Disabilities Act (ADA) of 1990.

A person that qualifies as disabled according to the definitions of the ADA regulation is given the opportunity to use JATA services at a reduced rate. Due to HIPPA law, JATA is unable to verify ADA applicants' criteria, therefore; we trust that your inference follows ADA guidelines as stated in Section 12102 of the Federal ADA Regulations. *(Possession of a Medicare Card or proof of Social Security Disability Income will serve as documentation for a reduced rate).*

► **Please inform your client if the ADA qualification is temporary.**

Please fax your response to me at 517-787-6833. If you have any questions you may contact me at 517-780-3775.

The client must present identification when picking up their Half-fare Card.

Patient's name:

_____

PLEASE PRINT

Permanent disability ☐

Temporary disability ☐ Expected duration: From_____ To _____

Patient meets ADA requirements: Yes ☐ No ☐

Name _____ **Phone**_____

Please Print

Agency/Medical Facility_____ **Date**_____

Sincerely,

Debbie Brown- Tederna

Office Manager