COLT
City of Loveland Transit

City of Loveland

Application for Persons with Disabilities Fixed Route Annual Pass Only

The information in this application will only be used by COLT, to determine eligibility for a DISABLED ANNUAL BUS PASS.

The Americans with Disabilities Act of 1990, refers to a disability with respect to an individual, with a physical or mental impairment that substantially limits one or more of the major life actives of an individual, with a record of such impairment; or being regarded as having a such impairment.

To qualify (only one (1) required to qualify):

- □ You may present a Medicare Card and Identification Card at the COLT Office.
- □ Disabled Veterans Validation- Applicant has a **service-connected** disability. Applicant must provide a copy of a benefit letter from the Veteran's Administration. The letter must state the disability is **service connected**.
- □ Health care Provider's Validation
  - Your current health provider must provide COLT with information pertaining to your health condition or disability.
  - Please provide your health care provider's contact information. The COLT office will contact them directly to determine eligibility.

Applications can be returned to the COLT office, by mail, FAX or email. Once COLT receives the application, we will then contact your health care provider. Once an eligibility determination has been made you will be notified by mail.

Personal Information		
First Name:	Last Name	Middle Initial
Street Address		Apartment #
City	State	Zip Code
Primary Phone	Secondary Phone	Gender ___Female ___Male
Date of Birth _____/ _____/_____	Signature:_____	

To return application by Mail:
COLT
105 West 5th St
Loveland, CO 80537

Fax: 970 962 2936

Email: COLT@cityofloveland.org

Questions? Please call the COLT office at 970 962 2700 or TTY 970 962 2970 8am-5pm Monday-Friday. Materials are available in large print and other alternative formats. Assistance for non-English applicants is also available.

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Authorization to Release Medical Information

In order to allow COLT to evaluate your request for transportation under the Americans with Disabilities act of 1990, it is necessary to contact a health care provider that is familiar with your disability. Please give the name, address and telephone number of your current health care provider that is most familiar with your specific health condition or disability.

Name of Professional: _____Title_____

Address: _____

Phone: _____ Fax: _____

I authorize the above named health care provider to release information to the City of Loveland Transit (COLT). I understand that this information will be used exclusively to determine my eligibility for an annual fixed Route pass at a discounted rate. I understand that this information will be valid for 90 days. I understand that I may revoke this medical release at anytime.

Applicant Name (Please Print):_____

Signature of applicant or legal representative: _____

Today's Date: _____ Applicant's Date of Birth: _____

For COLT office use only:

Pass Number: _____ Pass Date Range_____

Approved/Sold by_____ Date_____

Comments:_____

Amount Paid_____ Private Payer Agency Payer

Employee Signature _____