



Franklin Regional Transit Authority 12 Olive St, Greenfield MA 01301  
[www.frtc.org](http://www.frtc.org) Tel: (413)774-2262

### DEMAND RESPONSE APPLICATION

This application will be used solely to determine Demand Response eligibility for Franklin Regional Transit Authority. Transportation is curb-to-curb and service may be limited depending on where you reside. Please complete this application to the best of your ability. Incomplete applications will be sent back to you for processing. ***Please note that a determination of your eligibility will be made by the FRTA within one week of receipt of a completed application. Faxed copies will not be accepted.***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City or Town: \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone Home \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please provide us with the name and telephone number of someone we can call in the event of an emergency.

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Telephone Day: \_\_\_\_\_ Night: \_\_\_\_\_

Please complete the following to see if you meet the criteria for Demand Response Transportation. Check all boxes that apply:

- ☐ I am a LifePath client and my authorization expires \_\_\_\_\_
- ☐ I am 60 years old or older, attached is proof of age
- ☐ I currently reside in a nursing home facility: \_\_\_\_\_  
Please indicate the duration of your stay: \_\_\_\_\_

- ☐ I am a Veteran with a disability rating of 70% or greater (please attach a letter from the VA, signed by a Veterans Services Officer specifying your disability rating)

**>Please indicate what type of mobility device is used (if any):**

Wheelchair \_\_\_\_ Cane \_\_\_\_ Walker \_\_\_\_ Other \_\_\_\_\_

I hereby understand that in order to be eligible to use Demand Response service, I must meet the above criteria. All Demand Response and ADA consumers are required to wear seatbelts in accordance with Massachusetts General Laws *unless* there is documentation of a medical condition that prohibits their use. Refusal to wear seatbelt will be documented by the driver and the FRTA will not be held liable for injury as a result of this.

I agree that if any of the information given to the FRTA is materially false or misleading, the FRTA shall have the right to reconsider my eligibility for services. I certify that the information given above is correct:

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

If this application is being filled out by someone other than the person requesting certification, please complete the following:

Name: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

Once you have been determined eligible for services based on the above information, the FRTA will notify you in writing within one week of receipt of this application with instructions on how to utilize our service and book your trips.

- ☐ I am currently receiving Mass Health benefits and wish to be contacted to find out how I may be eligible to receive no cost medical transportation.
- ☐ I wish to be contacted to find out about the fixed route schedule and how to use the public bus.

Revised April 1, 2019