



OFFICE OF  
COMMISSIONERS OF MIAMI COUNTY

Transit Department – Sarah Baker – Transportation Manager  
2036 N. Co. Rd. 25A \* Troy, OH 45373-2984 \* Ph. (937) 440-5488 \* FAX (937) 440-5487  
sabaker@miamicountyohio.gov

**Miami County Public Transit Application for ED/Disabled Rider Cards**

Check the appropriate option: (Select One Only) \_\_\_\_\_Elderly \_\_\_\_\_Disabled

Do you use one of the following: \_\_\_\_\_Wheelchair \_\_\_\_\_Walker \_\_\_\_\_Cane \_\_\_\_\_Other

**Requirements:**

- *Elderly Program:* Must be 65 or older. **Must provide proof of age.**  
(**Copy** of either your State ID, Driver’s License, or Birth Certificate)

**OR**

- *Disabled Program:* **Must provide document showing proof of disability.**  
(**Copy** of your Social Security Award Letter or Note from your Dr. on a prescription pad or office letterhead stating you have a permanent disability.)

**Please make sure you sign all documents and return with a copy of your proof of age/disability.**

**All lines must be completed .**

Name: \_\_\_\_\_  
First Name MI Last Name  
(Must have)

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

Phone Number: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Applicant/Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\***(Office Use Only)**\*\*\*\*\*

Signature of Eligibility Worker: \_\_\_\_\_

Date application received into the agency: \_\_\_\_\_ Date eligibility established: \_\_\_\_\_

# \_\_\_\_\_



2036 North County Road 25-A, Troy, Ohio 45373 Ph. (937) 440-5488 Fax (937)440-5487

Miami County Transit would like to inform you that as an Elderly and/or Disabled (blue card) applicant, you are eligible to be considered for door to door assistance.

If you are interested in door to door assistance, please fill out the attached form and return it with your application.

Please direct any questions to the Miami County Transit staff at (937)-440-5488.

**DOOR TO DOOR CLIENT ASSISTANCE REQUEST**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PLEASE SELECT ONE OPTION IF APPLICABLE.**

LIMITED MOBILITY

MOBILE DEVICE

COMMENTS/QUESTIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_