



Livonia Community Transit

To qualify for Veterans transportation through Livonia Community Transit, you must be a Livonia resident and meet one of the following criteria:

1. Financial Need. **Complete sections 1, 2 and 4**
2. Disability. **Complete sections 1, 3 and 4**

Note: If you meet any of the following criteria, you already qualify. **Please complete sections 1 and 4**

- been referred by the **Veterans Administration** in Ann Arbor
- submitted a **City of Livonia’s Property Tax Exemption** for eligible disabled veterans or
- submitted a **Livonia Community Transit ADA Application**

Veterans Certification Application

Section 1: Applicant Information ALL

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State Zip Code

Phone: _____ Email: _____

Date of Birth: _____

QUALIFYING CRITERIA - PLEASE CHECK ALL THAT APPLY:

Valid Michigan Driver License or State ID? (to confirm residency)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Livonia Transit ADA Application?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Military Identification?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Referred by the VA (Ann Arbor)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Property Tax Exemption Documentation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>			

Section 2: Financial Need ONLY

Income can come in the form of Social Security, SSI, unemployment, alimony, child support, etc. Proof of income upon request.

Monthly Income: \$ _____

Income Source: Soc. Sec. Employment Company Name: _____
 SSI Pension
 Other: _____

Does applicant live alone? YES NO

If NO, does any person with whom the applicant lives with share the applicant's expenses (i.e. food, shelter, clothing, etc.) YES NO

If YES, please list household members below:

Name	Relationship	Monthly Income

Combined monthly income of these persons: \$ _____

Section 3: Disability ONLY

Disability Documentation: DD Form 214 _____ Other _____

What is the nature of your disability? _____

Is the disability temporary? YES NO If YES, expected duration until ____/____/____

Do you travel with a personal care attendant?

ALWAYS (If checked, please specify the circumstances)

SOMETIMES (If checked, please specify the circumstances)

NEVER

Are there any other effects of your disability that should know about? Please explain _____

Please check one mobility aid that you will most often use when riding Livonia Transit:

- MANUAL WHEELCHAIR POWERED SCOOTER ELECTRIC WHEELCHAIR
 LARGE WHEELCHAIR CANE OR WALKER SERVICE ANIMAL

Section 4: In Case of Emergency ALL

Name: _____ Phone: _____
Relationship: _____

Disclaimer and Signature ALL

By signing this document, I hereby give the City of Livonia, its officers, agents and employees, including but not limited to the Livonia Community Transit, permission to review and consider the financial and medical information set forth above to determine my eligibility to utilize the Livonia Community Transit system. If Livonia Community Transit observes an incident where my safety is in question, they have the right to evaluate my ability to continue riding Livonia Community Transit. I hereby waive my right of privacy, if any, relative to the medical information set forth herein. I certify that the information I gave in this application is true and correct.

Applicant's Signature: _____ Date: _____

Certifier's Signature: _____ Date: _____