Office Use Only	Name _____	ADA# _____	Exp. Date _____

Do not write above this line — Office Use Only

REQUEST FOR CERTIFICATION FOR ADA DIAL-A-RIDE ELIGIBILITY

The American with Disabilities Act (ADA) requires that disabled individuals be guaranteed access to transportation services. By filling out this application for Dial-A-Ride Certification, services are provided for disabled persons unable to use fixed-route transportation.

HOW TO APPLY FOR DIAL-A-RIDE ELIGIBILITY CERTIFICATION

1. Applicant (or representative) completes PART A, pages 2-6. Signature and date are **required** on page 6. **Application cannot be processed without a signature and date.**

2. Health Care Professional completes PART B, pages 8-10, guided by the criteria explained herein. On page 7, near the top, fill in applicant's name. Health Care Professional's signature and date are **required** on page 10. Application cannot be processed without a signature and date.

3. Fill out the checklist on Page 2 and send completed application to:
   Pacific Transit System
   Attn: Dial-A-Ride Supervisor
   216 2nd Street
   PO Box 489
   Raymond, WA 98577
   Fax: (360) 942-3193
   Email: dispatch@pacifictransit.org

4. Pacific Transit System will notify you of your eligibility status. This process will take 1-3 weeks. Once we have your application in the office you will be temporarily eligible to ride the Dial-A-Ride until a determination is made.

5. After 21 days of Pacific Transit System receiving your application, you have not heard about your application, please call (360) 875-9418 or (360) 642-9418.

6. If you are denied eligibility, you will have a right to appeal the eligibility decision. Please contact Pacific Transit System (360) 875-9418 or (360) 642-9418 for the appeals process policy. The applicant must file an appeal within sixty (60) calendar days from the date of the notification of the denial.

NOTE: The Dial-A-Ride Certification is for a three-year period unless your Health Care Professional provides a temporary eligibility. Another application must be filled out to continue Dial-A-Ride eligibility upon expiration of the Certification.

CERTIFICATION PROCESS:

1. Applicant (or representative) completes PART A.

2. Health Care Professional completes PART B guided by the criteria explained herein.

3. Dial-A-Ride Dispatcher may contact the certifying Health Care Professional to verify the accuracy of the information.

4. Dial-A-Ride Dispatcher will make the final determination as to the applicant's eligibility.

5. Applicant will receive a letter and Certification Card once eligibility is determined.

This application must be filled out COMPLETELY for processing to occur.

Checklist:

☐ Fill out all applicable sections of Part A

☐ Sign and Date Page 6 **(Unsigned and dated applications will be rejected)**

☐ Write your name on Page 7 **(If your name is not filled in on Page 7, the application will be rejected)**

☐ Health care provider's signature, date and professional licensure information, if applicable on Page 10 **(Unsigned/dated applications will be rejected)**

PART A: APPLICANT INFORMATION

1. NAME OF APPLICANT:_____
2. PHYSICAL ADDRESS: _____

   CITY_____STATE_____ZIP_____
3. MAILING ADDRESS:(If different from physical address)

   CITY_____STATE_____ZIP_____
4. PHONE (Main Phone):_____

   Other daytime phone number_____
5. DATE OF BIRTH:_____/_____/_____
6. MALE _____ FEMALE _____

CHECK THE CATEGORY AND ALL CRITERIA THAT APPLY OR PROVIDE DESCRIPTION:

_____ CATEGORY 1

I have a physical, mental, or visual disability or impairment which PREVENTS me from utilizing fixed-route buses without an attendant for:

1. _____Boarding the bus
2. _____Riding the bus
3. _____Disembarking the bus
4. _____Other (describe)_____

   _____

_____ CATEGORY 2

I can use buses with wheelchair lifts, but:

1. _____Buses with wheelchair lifts are not available in my area
2. _____Wheelchair lifts cannot be deployed at my stop(s). List location(s)

_____ CATEGORY 3

I can use accessible buses but have an impairment-related condition which prevent me from traveling to or from a bus boarding location. Describe the impairment condition:

_____

_____

_____

MOBILITY DEVICES

Do you use any of the following aids? (check all that apply)

_____Manual Wheelchair*	_____Cane
_____Power Scooter*	_____White Cane
_____Crutches	_____Walker
_____Service Animal	_____Boarding Chair
_____Hearing-Aid	_____Brace
_____Communications Board	_____Oxygen Bottle
_____Prosthesis	_____Other:
_____Electric Wheelchair*	_____

*Please note that your trip original and destination must be accessible by ramp or lift. IF NOT ACCESSIBLE, please have someone available to assist you up and down steps. Drivers are not permitted to assist applicant up or down any steps or manage a power scooter.

REASONABLE MODIFICATION

Pacific Transit System is a curb-to-curb service. Occasionally due to the disability, a door-to-door service will be needed, or other accommodations needed to ride the bus or van. This is known as a reasonable modification. Pacific Transit System will do its best to accommodate reasonable modifications for the applicant but will consider the safety of its passengers first. Pacific Transit

System will deny a reasonable modification request if it will result in a service alteration, direct threat to safety, or is an undue financial and administrative burden. **Keep in mind that the driver will not go inside an applicant's house or in a facility.**

If you need a reasonable modification, state below the modification needed and why it is needed to allow the applicant use of the bus or van.

_____

_____

_____

OTHER MISCELLANEOUS

Are there any other effects of your disability which we need to be aware of?

_____Obesity/weight _____Seizures

_____Paralysis _____Need for catheter

_____Shortness of breath _____Dizziness

_____Other, please explain_____

_____

_____

PERSONAL CARE ATTENDANTS

Do you require a Personal Care Attendant (PCA)* when you ride the bus?

Yes_____ No_____

*** Pacific Transit System does not provide Personal Care Attendants.**

PCA must be available to accompany applicant with or without mobility device when the applicant cannot travel by themselves or needs help with out without their device into or from a facility.

EMERGENCY CONTACT

In case of emergency, is there someone who should be notified?

Yes_____ No_____

If yes, please complete the following:

NAME:_____

ADDRESS:_____

PHONE NUMBER:_____ _

RELATIONSHIP:_____

APPLICANT'S SIGNATURE AND AUTHORIZATION TO RELEASE INFORMATION

In order to allow Pacific Transit System to evaluate your request for certification, it may be necessary to contact your Health Care Professional to verify information you have provided.

I hereby certify that the information given above is true and correct.

I, therefore, give authorization by my Health Care Professional to release information to Pacific Transit System.

_____ _____

Applicant's Signature Date

SIGNATURE REQUIREMENT OTHER THAN APPLICANT

If you have completed this application certification for the requesting applicant, you must provide the following information.

I hereby certify that the applicant's information given is true and correct.

NAME:_____

ADDRESS:_____

PHONE NUMBER:_____

SIGNATURE:_____ DATE:_____

PART B: PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked by _____(applicant) to provide information regarding their ability to use out transit services. Federal law requires that Pacific Transit System provide services to persons who cannot used fixed-route transit service. The information you provide will allow us to evaluate this request and its application to specific trip requests. Thank you for your cooperation in this matter.

To qualify for DIAL-A-RIDE service, a person must be unable to use fixed-route public transportation due to a physical or mental disability. Individuals qualify if:

1. As a result of their disability, they cannot board, ride, or disembark from a Pacific Transit System fixed-route bus; or

2. They have a specific impairment-related condition which prevents them from getting to or from the bus stop.

*PLEASE NOTE: This does not include persons who find it uncomfortable or difficult to get to or from a bus stop.

Your evaluation of each person must be based solely upon the individual's ability to use a fixed-route bus. Your verification should consider only the presence of a disabled condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this DIAL-A-RIDE Certification. False verification could result in travel limitation for persons legitimately qualified to use the DIAL-A-RIDE Program.

FILLING OUT THE FOLLOWING

DIAL-A-RIDE Service is a limited special transportation service for disabled person who, because of a physical or mental disability, find it IMPOSSIBLE to use fixed-route transportation. Parts A, B, C, D, and E must be filled out completely by authorized health care professionals who signs below. Incomplete applications will be returned.

A. Nature of Disability:

Check nature of applicant's disability (check as many items as may apply).

1. _____Arthritis: Specific extremity_____
2. _____Amputation: Specific extremity_____
3. _____Cerebrovascular accident (stroke)
4. _____Pulmonary illness:
   Does applicant use portable oxygen tank? Yes_____ No_____
5. _____Neurological disability
6. _____Cardiac ills
7. _____Kidney disease: Dialysis? Yes_____ No_____
8. _____Sight disability: legally blind _____visually impaired_____
9. _____In-coordination
10. _____Developmental disability Moderate_____Severe_____Profound_____
11. _____Cerebral palsy
12. _____Muscular Dystrophy
13. _____Autism: Describe degree of severity_____
14. _____Severe muscle spasms
15. _____Seizures
16. _____Loss of consciousness
17. _____Mental illness-Please specify what it is about this cognitive disability that makes this individual unable to use the fixed-route bus service:

    _____
    _____
    _____
18. _____Other disabilities not listed above_____
    _____
    _____
    (Please specify what it is about this disability that makes this individual unable to used the fixed-route bus service):
    _____
    _____
    _____

B. Ambulatory or Non-Ambulatory:

_____Ambulatory

_____Non-Ambulatory (Impaired or assisted ambulation)
Mobility aid_____
_____Assisted by Service Dog

C. Disability Duration:

(Certification duration is for a three-year period, unless temporary is marked)

_____Permanent or _____Temporary
If temporary, expected duration is _____months

D. Personal Care Attendant Requirement:

In your opinion, must this individual bring a Personal Care Attendant to accompany the applicant to help with their mobility device; or to accompany the applicant because they cannot travel by themselves; or the applicant needs help with/without their device into or from a facility? **Pacific Transit System does not provide Personal Care Attendants.**
Yes_____ No_____

E. Other Information

Is there any other effect of the disability of which Dispatch should be aware of? Please provide an explanation:

_____

_____

_____

_____

_____

HEALTH CARE PROFESSIONAL INFORMATION

My professional area is (check one)

Physician	_____	Independent Counselor	_____
Rehabilitation Counselor	_____	Social Worker Professional	_____
Occupational Therapist	_____	Ophthalmologist/Optometrist	_____
Psychologist	_____	Registered Nurse	_____

Other:_____

YOUR NAME :_____

TITLE:_____

AGENCY/COMPANY NAME:_____

PROFESSIONAL LICENSE # (If applicable):_____

OFFICE ADDRESS:_____

OFFICE PHONE NUMBER: _____

I hereby certify that the above information is true and correct. Dispatch may verify the validity of the license and/or information given from the health professional providing the certification.

_____ _____

Signature of Health Care Professional Date

Mail completed application/section to:
Pacific Transit System
Attn: Dial-A-Ride Supervisor
216 N. 2nd Street
PO Box 489
Raymond, WA 98577
Fax (360) 942-3193
Email dispatch@pacifictransit.org

Thank you for your assistance

Revised 9/12/2023