

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@pacificttransit.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 use 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 _____
Rehabilitation Counselor _____
Occupational Therapist _____
Psychologist _____
Other: _____

Independent Counselor _____
Social Worker Professional _____
Ophthalmologist/Optomtrist _____
Registered Nurse _____

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@pacificttransit.org

Thank you for your assistance

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