

**REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY  
DIAL-A-RIDE**

**This portion is to be filled out by applicant - Please print.**

The information obtained in this certification process will only be used by Dial-A-Ride for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other agency.

1. Name \_\_\_\_\_

2. Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

3. Telephone Number (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

4. What do you claim is the disability which prevents you from using our fixed route service? \_\_\_\_\_

\_\_\_\_\_

Is this condition temporary? No \_\_\_\_\_ Yes \_\_\_\_\_  
If yes, how long? \_\_\_\_\_

5. How does this disability prevent you from using fixed route services? Please explain completely. Use additional paper if necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

7. Do you use any of the following mobility aids? (Check all that apply)

Manual Wheelchair \_\_\_\_\_ Electric Wheelchair \_\_\_\_\_ Service Animal \_\_\_\_\_  
Cane \_\_\_\_\_ White Cane \_\_\_\_\_ Crutches \_\_\_\_\_ Other (explain) \_\_\_\_\_

8. Do you require a Personal Care Attendant/Escort when you travel using transit?

No \_\_\_\_\_ Yes \_\_\_\_\_ (if yes, why?) \_\_\_\_\_

\_\_\_\_\_

9. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?

Yes\_\_\_\_ No\_\_\_\_ Sometimes Describe\_\_\_\_\_

Can you climb three 12-inch steps without assistance?

Yes\_\_\_\_ No\_\_\_\_ Sometimes Describe:\_\_\_\_\_

Can you wait outside without support for 15 minutes?

Yes\_\_\_\_ No\_\_\_\_ Sometimes Describe:\_\_\_\_\_

10. I hereby certify that the information given above is correct.

Signed\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_

(Applicant's signature)

In order to allow Dial-A-Ride to evaluate your request, it may be necessary to contact a physician to confirm the information you have provided. Please complete the following:

**Release of Information**

The following Physician\_\_\_\_\_ is familiar with my disability and is authorized to provide the information to Dial-A-Ride required to complete this certification.

Name\_\_\_\_\_

Address\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_

Phone Number\_\_\_\_\_

Signed\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_

(Applicant's signature)

11. If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name\_\_\_\_\_ Address\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_

Daytime Phone\_\_\_\_\_ Relationship\_\_\_\_\_

Signed\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_

**REQUEST FOR PROFESSIONAL VERIFICATION**

**This section is to be completed by a physician - Please type or print.**

The applicant has signed a Release of Information on the previous page and would like to thank you for your assistance with this application. He/she is applying for paratransit transportation services, known as Dial-A-Ride, and the following information is needed in order to assist with a qualifying disability determination which is required in order to use the transportation system.

What is the medical diagnosis of the applicant’s disability? \_\_\_\_\_

How would this medical condition restrict the applicant’s ability to use a regular transit system?

Is the condition temporary? No\_\_\_ Yes\_\_\_ Expected duration:\_\_\_\_\_

If the person has a disability affecting mobility, is this person:

Able to walk 200 feet without assistance? Yes\_\_\_ No\_\_\_

Able to climb three 12-inch steps without assistance? Yes\_\_\_ No\_\_\_

Able to wait outside without support for 15 minutes? Yes\_\_\_ No\_\_\_

Does this person use mobility aids? If so, what kind?

Is the applicant visually impaired? Explain.\_\_\_\_\_

Is there a cognitive impairment? No\_\_\_ Yes\_\_\_ If yes, can this applicant:

Give addresses and telephone numbers upon request? Yes\_\_\_ No\_\_\_

Recognize a destination or landmark? Yes\_\_\_ No\_\_\_

Ask for, understand, and follow directions? Yes\_\_\_ No\_\_\_

**Does this person require a personal care attendant/escort to help with their mobility?**

**Yes\_\_\_ No\_\_\_**

Your Name:\_\_\_\_\_ Office Address:\_\_\_\_\_

(Print or type)

\_\_\_\_\_ Office Phone Number\_\_\_\_\_

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

(Physician’s Signature)

(License Number)

**Note: This application must be signed by applicant’s physician. Stamped signatures not accepted.**

**APPLICANT:** Please follow the directions on the back of this page.

**APPLICANT:**

Please mail or bring this completed application (the physician section must already be completed and signed) to the agency that will make your paratransit eligibility determination for Dial-A-Ride transportation services.

Lower Savannah Council of Governments (LSCOG)  
PO Box 850  
Aiken, SC 29802  
(803) 649-7981

@ 2748 Wagener Road, Aiken, SC 29801

Your eligibility determination will be made 21 days within receipt of this completed application. You will be notified by letter and, if applicable, your Dial-A-Ride identification card will be inside. If you are denied eligibility, you may appeal the decision and the appeals process will be mailed to you with your decision letter.

After approval, your ride will be arranged through Lower Savannah Council of Government's transportation provider of Dial-A-Ride services, **THE AIKEN AREA COUNCIL ON AGING. You will be making your future travel reservations through their transportation department**

**648-6493**

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Please keep in mind that pick up and delivery destinations **MUST** fall within established service areas in Aiken County and that Dial-A-Ride transportation is not available outside the service areas or outside normal operating hours. Brochures describing the program are available from LSCOG. Please call 649-7981 and ask for the mobility manager for Dial-A-Ride with questions or requests for assistance.

OFFICE USE ONLY

DAR Eligible? \_\_\_\_\_ Card# \_\_\_\_\_ Effective Date \_\_\_\_\_

Decision Letter mailed \_\_\_\_\_ Personal Care Attendant/Escort

Approved \_\_\_\_\_

Staff Member \_\_\_\_\_

DATE STAMP HERE