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?

No ☐ Yes ☐ Sometimes Describe _____

Can you climb three 12-inch steps without assistance?

No ☐ Yes ☐ Sometimes Describe _____

Can you wait outside without support for 15 minutes?

No ☐ Yes ☐ 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 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 this 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 _____

Office Phone Number _____

Signature _____ License Number _____

(Physician's Signature)

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

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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.

Aiken Senior Life Services (ASLS)
1310 East Pine Log Road
Aiken, SC 29803
(803) 648-5447 ext. 2340

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 *Aiken Senior Life Services (ASLS)* transportation provider of Dial-A-Ride services. **You will be making your future travel reservations through their transportation department**

803-648-5447 ext. 2340

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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 ASLS. Please call 803-648-5447 ext. 2340 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 (Date) _____

Personal Care Attendant/Escort Approved _____

Staff Member Name _____

Staff Member Signature _____

DATE STAMP HERE

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