

MADERA DIAL-A-RIDE

123 North "E" Street
Madera, CA 93637
(559) 661-RIDE (7433)

APPLICATION FOR ADA PARATRANSIT ELIGIBILITY

This application will be used to determine if you are eligible for priority service on Madera Dial-A-Ride (DAR) under the Americans with Disabilities Act (ADA). DAR serves the general public with an emphasis on senior and disabled riders. See the City of Madera Paratransit Service Plan for more details (available at www.cityofmadera.org or call 559-661-3689).

If you believe you have a disability that prevents you from using fixed-route services, such as MAX, please complete this form. This application may be filled out by you, a relative or a friend. It is important that you answer every question on this application. Evaluation of your request cannot begin until we have received the completed form. Please note that a doctor's statement is not required; however, we may need to contact a licensed professional for verification. Please return your application to the address at the top of this page. All information requested through this certification process will be kept confidential. Please call Madera DAR staff at (559) 661-RIDE (7433), if you have any questions or if you need an alternative format.

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Once your completed form has been received, you may expect an answer within 21 calendar days. In the event processing takes longer than 21 days, eligibility will be presumed until notified. Qualifying applicants will be issued an ADA Paratransit Eligibility card. Denial of eligibility may be appealed in writing to the City of Madera, Transit Division at 205 West 4th Street, Madera, CA 93637 or by calling 559-661-3689.

MADERA DIAL-A-RIDE ADA APPLICATION

123 North "E" Street, Madera, CA 93637 Phone: (559) 661-7433

Denied: ___/___/___ Notice Sent: ___/___/___ Appeal Rec'd: ___/___/___

NAME: _____ DATE OF BIRTH: ___/___/___
First Middle Last Mo Day Year

ADDRESS: _____
Street City State Zip

PHONE: (Day) ___ - ___ (Evening) ___ - ___ TDD? Yes ___ No ___

EMAIL: _____

Describe in your own words the disability that **prevents** you from using fixed-route bus service and how.
(Use extra sheet, if necessary): _____

Is this condition temporary? If yes, expected duration until ___/___/___

Please check all of the following mobility aids you use:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Motorized Wheelchair | <input type="checkbox"/> Powered Scooter | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Other (please explain) _____ | | | |

Please answer **all** the following questions:

How far can you travel without the assistance of another person? _____ feet or _____ blocks

Can you climb 12-inch steps without the assistance of another person?
Yes ___ No ___ Sometimes ___ If no or sometimes, explain _____

Can you wait at a bus stop without support for 10 minutes?
Yes ___ No ___ Sometimes ___ If no or sometimes, explain _____

Is your disability affected by temperature or weather?
Yes ___ No ___ Sometimes ___ If yes or sometimes, explain _____

Do you need an attendant or assistant to help you with your trip or trip purpose?
Yes ___ No ___ Sometimes ___ If yes or sometimes, explain _____

Do you have difficulty in understanding how to use the bus or how to find a bus stop?
Yes ___ No ___ Sometimes ___ If yes or sometimes, explain _____

It may be necessary to contact a physician or other licensed professional to confirm the information you have provided. Please complete and sign the following information:

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Health Care Professional | <input type="checkbox"/> Rehabilitation Professional |
|------------------------------------|---|--|

Name: _____

Address: _____

Phone: _____

I hereby certify that the information provided in this application is correct, and I agree to the release of this information to Madera Dial-A-Ride for the purpose of ADA eligibility certification.

Signed: _____ Date: _____

If assistance was provided in filling out this form, please indicate by whom:

Name: _____ Relationship: _____

Phone: (Day) _____ - _____ (Evening) _____ - _____

Please mail your completed application to:

City of Madera
ATTN: DIAL-A-RIDE ADA APPLICATION
123 North "E" Street
Madera, CA 93637

FOR OFFICE USE ONLY

Received: ____/____/____

Permanent Certification: Issued: ____/____/____ Expires: ____/____/____

Temporary Certification: Issued: ____/____/____ Expires: ____/____/____

Denied: ____/____/____

Notice Sent: ____/____/____

Reviewed By:

Name _____ Title: _____

Signature: _____ Date: _____

Appeal Received: ____/____/____

Appeal Determination: ____/____/____

Permanent Certification: Issued: ____/____/____ Expires: ____/____/____

Temporary Certification: Issued: ____/____/____ Expires: ____/____/____

Denied: ____/____/____ Reason: _____

Notice Sent: ____/____/____

Reviewed By:

Name: _____ Title: _____

Signature: _____ Date: _____

5/29/15