City of Madera Transit Services • Dial-A-Ride (DAR)

PARATRANSIT APPLICATION | ADA CERTIFICATION FORM

Madera Transit Center • *1951 Independence Drive, Madera, CA 93637*

Name:_____Date of Birth:___/___/____
First Middle Last Mo. Day Year

Address:_____
Street City

State_____ Zip_____

Mailing Address (if different from above) _____

Phone Number:_____ Alternative Phone Number _____

Email:_____

Do you require future information to be provided in an alternative format? ☐ Yes ☐ No

If yes, please specify: ☐ Large Print ☐ Audio Tape ☐ Braille ☐ TTY/TDD

Are you able to independently get to and from a regular Madera Metro fixed-route stop?

☐ Yes ☐ No ☐ Other (please specify):_____

Are you able to get independently on and off a Madera Metro transit vehicle without assistance?

☐ Yes ☐ No ☐ Other (please specify):_____

Are you restricted to a wheelchair? ☐ Yes ☐ No If yes, is it motorized? ☐ Yes ☐ No

Do you use a mobility device such as a cane or a walker? ☐ Yes ☐ No ☐ Occasionally

Will you be traveling with a personal care attendant? ☐ Yes ☐ No ☐ Occasionally

Will you be traveling with a rider companion? ☐ Yes ☐ No ☐ Occasionally

Will you be traveling with a service animal? ☐ Yes ☐ No

What type of transportation do you currently use?

☐ Drive Self / private auto
☐ Madera Metro Fixed Route
☐ Walk
☐ Friend / Family Member
☐ Tax
☐ Other (please specify):_____

Do you have any difficulty in understanding how to use or navigate the City's Transit Service system?

☐ Yes ☐ No

Can you climb steps without the assistance of another?

☐ Yes ☐ No ☐ Unsure

Please provide an emergency contact:

Name_____ Relationship_____

Address_____

City, State, Zip_____

Phone Number_____

AGREEMENT AND AUTHORIZATION

I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to service operators. I agree to abide by the rules and procedures of the City of Madera Transit Services Dial-A-Ride Program.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Applicant's Signature_____ Date_____

I hereby authorize the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition to release this information to my local public transit agency. This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Applicant's Signature_____ Date_____

Name of Licensed Professional who may release my medical information:

Name: _____

Address: _____

Phone Number: ( ) _____ - _____

LICENSED PROFESSIONAL STATEMENT OF ADA ELIGIBILITY

Print Applicant's Name: _____

The Americans with Disabilities Act of 1990 requires Local Transit Operator to provide Paratransit services to individuals who, because of their medical condition or impairment are prevented from using fixed route buses. Economic status, and environmental conditions may not be considered "medical" factors in the assessment of paratransit eligibility. The information requested of you in the following sections will be used to determine the applicants' ADA eligibility. It is important that all questions be answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may need to contact you for clarification.

THIS SECTION TO BE COMPLETED BY ONE OF THE FOLLOWING:

☐Physician ☐Chiropractor ☐Health Care Provider ☐Physical Therapist

☐ Rehabilitation Counselor ☐ Other Licensed Professional_____

Is the applicant's disability condition permanent?

☐ Yes ☐ No

If no, how long do you expect the disability will last? _____

If a disability is temporary, it must last for at least 90 days to be eligible for ADA Paratransit Services.

Please provide a formal medical diagnosis describing the applicant's primary impairments or disabling conditions. **Applications without a formal medical diagnosis will be denied.**

_____
_____
_____
_____

_____ _____
License Professional's Name (Print) License's Professional's License # (Required)

_____
Signature (**must be original – copies, faxes, and/or stamped signatures cannot be accepted.**)

Date _____