BEND DIAL-A-RIDE

ADA PARATRANSIT ELIGIBILITY APPLICATION

This application will determine eligibility for passengers unable to ride a fixed route bus due to a disability that is temporary, conditional or permanent. It is important that applications are filled out completely. Any incomplete applications will be returned.

After Dial-A-Ride receives your application, what can you expect?

- If you believe you qualify for Dial-A-Ride, you will be allowed service for 30 days while you complete and submit an application.
- You will receive notice whether or not you are eligible within 21 days of receipt of your completed application.
- Once accepted, re-certification will be required every three (3) years.
- If denied, please contact the Dial-A-Ride office (541-385-8680) to discuss the appeal process.

If you need assistance completing this application, would like the application in an alternative format, or have additional questions about public transportation under the Americans with Disabilities act, contact the Dial-A-Ride office at: 541-385-8680 or the Accessibility Management office at: 541-693-2141. For persons with hearing or speech disabilities, call the Oregon Telecommunications Relay Service at 1-800-735-2900 TTY-Oregon Relay).

Please complete form and mail or fax to:
Cascades East Transit
343 E Antler Ave
Redmond, OR 97756
Phone 541-385-8680
Fax 541-548-9548

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

DOB_____ Address _____ Apt/Space # _____

Mailing Address if different _____

City_____ State _____ Zip Code _____

Cross Street _____ Name of Building or Facility _____

Name of person/party responsible for applicants mail _____

Telephone: Day _____ Evening _____

Optional Cell Phone _____ Fax _____ Email _____

EMERGENCY CONTACT PERSON

Please list two contact people to be notified in case of an emergency.

1. Name _____ Number(s) _____

Relationship to Applicant _____ Address _____

2. Name _____ Number(s) _____

Relationship to Applicant _____ Address _____

MOBILITY EQUIPMENT AIDS OR ASSISTANCE – This information will assist Dial-A-Ride in providing quality service.

1. Will you use any of these aids when riding Dial-A-Ride? (Check all that apply)
   - ☐ Cane, Walker, Crutches or White Cane
   - ☐ Service Animal
   - ☐ Communication Aid
   - ☐ Other_____
   - ☐ Portable Oxygen or other medical device
   - ☐ None of the above

2. Will you use a **wheelchair or motorized scooter** when riding Dial-A-Ride:
   - ☐ Yes ☐ No

a. If you use a wheelchair or motorized scooter, which device will you use?
   - ☐ Manual Wheelchair ☐ Motorized Wheelchair ☐ Motorized Scooter

b. Is the combined weight of you and your wheelchair or scooter more than 600 pounds?
☐ Yes ☐ No

c. Does your wheelchair or scooter exceed 48 inches in length or 30 inches in width?
☐ Yes ☐ No

Note: We cannot accommodate you if your wheelchair or scooter exceeds 48 inches in length 30 inches in width or the weight is more than 600 pounds when occupied.

APPLICANT'S ASSESSMENT FOR PARATRANSIT ELIGIBILITY

1. What prevents you from using the Cascades East Transit fixed route bus service? **(check all that apply)**
   ☐ Physical disability
   ☐ Hearing disability
   ☐ Visual disability
   ☐ Cognitive/Mental disability
   ☐ Other (explain) _____

2. Is the circumstance described above:
   ☐ Temporary ☐ Permanent

3. What circumstances prevent you from using fixed route transit?

_____

_____

_____

_____

4. Dial-A-Ride drivers are not able to perform the duties of a **Personal Care Attendant.** (A person who provides assistance during a ride or at a destination). Will you be accompanied by a Personal Care Attendant when riding Dial-A-Ride?
   ☐ Always ☐ Never ☐ Sometimes

5. When you arrive at your destination, does someone else need to be there to take responsibility for you before the driver leaves? ☐ Yes ☐ No

If yes, the emergency contact person you listed will be called if no one is available to receive you at your destination.

I certify that the provided information is correct:

Signature_____ Date_____

If completed by someone other than the applicant.

Signature_____ Date_____

APPLICANTS ABILITIES AND NEEDS (FUNCTIONAL ABILITY)

The Following Section **MUST BE COMPLETED by:**
Applicant's PHYSICIAN, or HEALTHCARE PROFESSIONAL

INSTRUCTIONS:
In deciding whether the applicant is eligible for the program please remember; an individual must have a disability and, as a result of their physical or mental impairment, they are on occasion, unable to board, ride, or exit from any accessible **Cascades East Transit fixed route bus.**
Please focus your response on the **functional ability of the applicant.** If an individual has a temporary medical condition, please provide information as to duration of that medical condition.

Client's Name: _____

1. Please check all the following that apply (functional ability) to the applicant:

   ☐ Can walk, use a wheelchair or scooter, etc., for 1/3 city block (approximately 200 feet) without help from another person?
   ☐ Can walk, use a wheelchair or scooter, etc., for 3 city blocks (1/4 mile) without help from another person?
   ☐ Can climb three 12 inch steps without help?
   ☐ Can wait outside for a bus for 30 minutes without help?
   ☐ Can travel to or from their home to a bus stop without assistance?
   ☐ Can get on and off a lift-equipped bus without help?
   Does the client have the cognitive ability to ride the fixed bus system? **Yes** **No** (circle one)

2. Does the client require curb-to-curb service? ☐ Yes ☐ No ☐ Sometimes

3. Does the client require door-to-door service (someone must help from door to bus)?
   ☐ Yes ☐ No ☐ Sometimes
   If yes, why? _____

4. Can the client, with the assistance of a working wheelchair lift or other boarding assistance device, board, **ride**, and exit a Cascades East Transit bus? **(Dial a Ride)**

   ☐ Yes ☐ No

Applicant's condition is:

Please check one:
☐ Permanent ☐ Temporary – From: _____ for how many months_____

☐ Conditional, could use fixed route under some circumstances.

Please explain the circumstances in which you feel the applicant would be functional (*able)* to use the regular Fixed Route system:

☐ Transport to and from fixed route
☐ Adequate training on system
☐ Other (describe)

_____

_____

_____

Name of Certifying Person **(Print)** _____

I certify that the information I have submitted is my medical or professional opinion on my client's functional ability to use the fixed route bus system.

Signature_____

Title _____Telephone_____

Agency _____ Date _____

Address_____

Please complete form and mail or Fax to:
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343 E Antler Ave
Redmond, OR 97756
Phone 541-385-8680
Fax 541-548-9548