Intercity Transit

Dial-A-Lift Application

For Office Use Only

Name_____

Map_____

ID#_____Code_____

Conditions_____

_____

Notes_____

_____

Date Received Date Processed

In compliance with the Americans with Disabilities Act of 1990 (ADA), Intercity Transit (IT) provides "Dial-A-Lift" services to anyone with a disability who cannot access the fixed route bus system. This service is intended only for those trips preventing a person with a disability from riding the fixed route bus system.

The following application is designed to assist IT staff in determining the most appropriate form of transportation for riders. This determination is based on a rider's ability and/or inability to access fixed route buses.

All of our fixed route buses are equipped with accessible features, allowing riders the freedom of travel without limitation throughout IT's service area.

INSTRUCTIONS FOR COMPLETING THIS FORM:

- **Be sure to review eligibility information on our website prior to completing the application.**

- **The applicant (or someone assisting them) must complete PART 1-7. The APPLICANT'S CERTIFICATION, Part 2 must be signed by the applicant (or guardian) prior to this application being processed.**

- **ALL applicants are required to have their health care provider complete the Dial-a-Lift Professional Certification Form (Part 8).**

- **All questions must be answered. Incomplete forms will be returned.**

- **If you have questions and/or need assistance, contact: Intercity Transit, Dial-A-Lift Services at: (360) 705-5896 or 1-800-244-6846**

- ***After attaching adequate postage* mail the *fully completed* application to: Intercity Transit/Dial-A-Lift , P.O. Box 659, Olympia, WA 98507-0659. You can also email your application to: DALeligibility@intercitytransit.com**

PART 1 GENERAL INFORMATION

Last Name:_____ First Name:_____ MI:_____

Street Address:_____ Apt/Bldg. #:_____

City:_____ State:_____ Zip:_____

Phone:_____ Date of Birth:_____

Sex: ☐ **M** ☐ **F** **Email**: _____

Mailing Address (if different from above):_____

City: _____ **State:_____ Zip:_____**

Please provide the name and phone number of someone we can call in an emergency:

Name:_____ Phone:_____

Relationship: _____

PART 2 APPLICANT'S CERTIFICATION

Please indicate below the reasons why you are seeking ADA Eligibility (check all that apply):

☐ **I can use fixed-route buses to go some places, but in other places I cannot get to or from the bus stops.**

☐ **I can use fixed-route buses sometimes if they are fully accessible.**

☐ **Because of my disability, I can never use the Intercity Transit fixed route buses.**

I understand the purpose of this application is to determine if there are times when I cannot use the Intercity Transit fixed-route buses and must use Dial-A-Lift instead. I understand the information about my disability contained in this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify, to the best of my knowledge, the information in this application form is true and correct. I understand providing false or misleading information could result in my eligibility being re-evaluated and/or terminated.

Applicant's Signature:_____ Date:_____

****** When signing for another individual, YOU MUST provide a copy of the document authorizing you to do so (i.e. Power of Attorney, Guardianship)***

If someone assisted you complete this form, please identify him or her below:

Name:_____ Phone:_____

PART 3 ***INFORMATION ABOUT TRAVEL TRAINING***

NOTE: **Travel Training is personal (one–on-one) instruction teaching an individual how to use fixed-route buses.**

Have you ever had any personal instruction/training on how to use the fixed-route bus?

☐ **NO, I have not received any personal instruction/training**

☐ **YES, I received personal instruction/training through an agency (Name of Agency):_____**

☐ **YES, I have received personal instruction from a friend/relative**

Please indicate below the skills you have learned:

☐ **Travel to and from a bus stop**

☐ **To cross streets**

☐ **To ride the following routes (please list them)**

Route #_____ Route #_____ Route #_____

☐ **To read bus schedules and to plan trips**

☐ **Other:_____**

Intercity Transit offers free instruction to anyone interested in learning how to ride Fixed-route buses. Would you be interested in getting information about this service?

☐ **YES**

☐ **NO**

If you are found eligible for Dial-A-Lift for some or all of your trips, would you like to receive automated phone reminders of your ride times? ☐ **YES** ☐ **NO**

PART 4 ***INFORMATION ABOUT APPLICANT'S DISABILITY***

1. **What type(s) of disability prevents you from using fixed route buses? Check all that apply.**
   ☐ Developmental Disability **☐ Physical Disability**
   ☐ Cognitive Disability

Please provide specific information about how your physical disability, mental disability or other disabling condition impacts your activities of daily living:

_____

_____

2. **Is the disability described above temporary or permanent?**

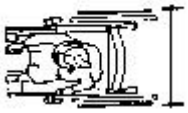
___Temporary, I expect my disability to last another _____months
___Permanent
___I do not know

3. **Please indicate below if you use any of the following mobility aids/equipment.**

___Cane	**___Long white cane**	**___Leg brace**
___Crutches	**___Walker**	**___Picture board**
___Alphabet board	**___Manual wheelchair**	**___Power scooter**
___Power wheelchair	**___Other: _____**	
___Service animal_____		**___None**

4. **If you use a wheelchair or scooter, what size is it?**

_____Length in inches **_____width in inches**



5. **Does the combined weight of your wheelchair/scooter and your own weight exceed 800 pounds?**

___YES **___NO**

6. **Do you require the assistance of a (PCA) Personal Care Attendant (someone who assists you with daily life functions)?**

___YES, I need assistance when I travel with:

___Mobility	**___Reading**	**___Eating**	**___Shopping**
___Medication	**___Transfers**	**___Communicating**	**___Other**

___NO

PART 5 QUESTIONS ABOUT USING FIXED-ROUTE BUSES

7. Have you ever used fixed-route buses?

___YES, I typically use the fixed route buses___times a week
___YES, I used to but stopped because (please be specific)_____
_____

___NO

8. Is there something that might help you to ride fixed route buses? Check all that apply.

___YES, route and schedule information ___YES, learning to use the buses
___YES, a communication aid ___YES, bus stops close to home
___YES, bus stops close to where I am going
___YES, _____
___NO

9. Can you ask for and follow written and oral instructions to use the fixed route buses?

___YES

___NO > > > > > > > > > > > > > > NO or SOMETIMES, please check:
___SOMETIMES > > > > > > > ___I get too confused and might get lost
___Other people cannot understand me
___I do not know because I have never tried to use the buses. ___I probably could with training
___Other:_____

10. Are you able to get to and from bus stops on your own?

___YES

___NO > > > > > > > > > > > > > > NO or SOMETIME, please check:
___SOMETIMES > > > > > > > ___I can't get places if there are no curb cuts
___I can't if the street or sidewalk is too steep
___I do not know because I have never tried ___I cannot cross busy streets and intersections
___I cannot travel outside when it is too hot
___I cannot travel outside when it is too cold
___I can't find my way at night because of a vision problem
___I get confused and cannot find my way
___I probably could with instruction
___I feel unsafe traveling alone
___Other:_____

11. Using a mobility aid or on your own, how far can you travel?

___I cannot travel outside my house/apartment
___I can get to the curb in front of my house/apartment
___I can travel up to 3 blocks (1/4 mile)
___I can travel up to 6 blocks (1/2 mile)
___I can travel up to 9 blocks (3/4 mile)

12. Can you wait up to 30 minutes at a bus stop?

___YES
___YES, but only if the stop has a bench and shelter
___YES, but I don't like to wait that long
___NO (explain):_____

13. Can you get on and off a fixed-route bus?

- ***As a reminder, all of our fixed route buses are ADA accessible, equipped with accessible ramps and a "kneeler" to lower the height of the bus. Passengers can ask the driver to "kneel" the bus or deploy the ramp to meet their individual accessibility needs.***

___YES

___NO > > > > > > > > > > > >	**If NO or SOMETIMES, please check:**
___SOMETIMES > > > > > > >	**___Only if the bus has a wheelchair ramp**
	___I cannot step onto the bus
___I do not know because I	**___I do not want to use the ramp**
have never tried	**___I probably could with instruction**
	___Other:_____

14. Can you get to a seat or wheelchair station by yourself?

___YES

___NO > > > > > > > > > > > >	**If NO or SOMETIMES:**
___SOMETIMES > > > > > > >	**___I need someone to help me**
	___I have a balance problem
___I do not know because I	**___I have trouble finding a seat**
have never tried	**___I need the seat nearest the door**
	___Other:_____

15. Can you determine where/when to get off the bus or can you find out by yourself?

___YES

___NO > > > > > > > > > > > >	**If NO or SOMETIMES:**
___SOMETIMES > > > > > > >	**___I get confused and cannot remember where I am going**
	___I can if the stops are called out or displayed
___I do not know because I	**___I probably could with training**
have never tried	**___Other:_____**

16. Are there any other <u>physical</u> condition(s) limiting your ability to use the fixed route buses?

___YES (Please describe them below):

_____

_____

___NO

PART 6 CURRENT TRAVEL INFORMATION

Please list three trips you plan to make most frequently using Dial-A-Lift.

Sample		
	From (Place and address)	**To (Place and address)**
1.	**101 N. Capitol Way**	**333 S. Custer Way**

	From (Place and address)	**To (Place and address)**
1.	_____	_____
2.	_____	_____
3.	_____	_____

PART 7 PERSONAL CARE ATTENDANT CERTIFICATION

Please provide the following information for your designated Personal Care Attendant

Name of Personal Care Attendant:_____
Last First MI

Phone:(home)_____ **Phone:(work)**_____

I certify I need the services of a Personal Care Attendant (PCA) to make independent travel possible. I understand a PCA is someone designated or specifically employed on a regular basis to assist me with the completion of at least one daily activity.

I will need a Personal Care Attendant: _____Permanently _____Temporarily _____Occasionally

If temporarily, what is the expected duration? _____.

I certify the information provided is true and correct.

Signature of Applicant:_____
***** When signing for another individual, YOU MUST provide a copy of the document authorizing you to do so (i.e., Power of Attorney, Guardianship).**

Do you need information and materials in another format? If yes, please check the appropriate item(s):

___Spanish ___Large Print ___Audio Recording ___Braille ☐ Other:_____

PART 8 ***PROFESSIONAL CERTIFICATION***

Intercity Transit Dial-A-Lift Professional Certification
** This is NOT a fillable form. Care Provider Must Complete**

Applicant's Name_____ Date of Birth_____

The above individual has applied for Americans with Disabilities Act Paratransit (Dial-A-Lift) Services and has listed you as their care provider. Dial-A-Lift is provided for individuals unable to access fixed route buses **due to their disability.** For this reason, your responses will assist us in determining eligibility. As a reminder, all of our fixed route buses are fully accessible (i.e. kneel and have ramps). Travel Training is also offered through our office at no cost for interested individuals.

Diagnosis

Please specify this individual's diagnosis or multiple diagnoses if applicable (provide ICD10 and DSM IV codes):

_____

_____

_____

Permanent? _____ Temporary? _____/How Long?_____

Is this condition-effected by weather/temperature? If so, specify weather type (hot, cold, both).

Mobility

Do you feel this individual can board a regular bus using the lift, handrails and/or by having the bus lowered to ground level?

Is walking detrimental to this individual's condition? If so, please explain

If walking is **not detrimental**, how far can is this individual travel doing a combination of walking/standing?

_____ ***9 blocks*** _____***6 blocks*** _____ ***3 blocks***

_____***2 blocks*** _____***other (please specify)***_____

Does this individual use a mobility device? _____No _____Yes

Please specify type of mobility device used: _____
If applicable, how far is this individual able to propel their mobility device without assistance from another individual?

_____ ***9 blocks*** _____***6 blocks*** _____ ***3 blocks***

_____***2 blocks*** _____***other (please specify)***_____

Is a Personal Care Attendant (PCA) necessary for safe travel?

Cognitive/Developmental/Mental Health

Does this disability affect cognitive functions? Please explain.

Is this individual stable or in remission? Yes____ No_____

If you have a copy of a psychological evaluation from the last three years please provide a copy.

Is this individual capable of recognizing destinations and comprehending what is happening around him/her? If not, please explain.

Is this person capable of using memory aids? If not, please explain.

Is this individual capable of utilizing the bus system with accommodations such as route planning assistance, and announcements of stops when riding? If not, please explain.

Travel Training

Travel Training is a free, self-paced training program for individuals who have the ability to use the regular route buses. Do you feel this individual could benefit from this program?

_____Yes _____No (Please Explain)_____

_____

I am a licensed medical provider or a qualified service provider with a state/county agency in the field indicated below and certify that the above-mentioned individual has the disability and limitations indicated above (RCW (A.72.085 & RCW 40.16.030)**.**

_____ _____

Professional Care Provider's Signature Date

_____

Professional Care Provider's Name **(Please Print)**

_____ _____

Mailing Address Area of Specialization

_____ _____

National Provider Identifier (NPI) **or** Tax ID Number * Phone

*This form considered incomplete without valid NPI or Tax ID Number.