

**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 (Primary _____ (Secondary) _____)

4. What do you claim is your condition or diagnosis that would restrict your ability to use a public transportation transit system, (i.e. city bus)?

Is this condition temporary? No _____ Yes _____
If yes, how long? _____

5. Are there any other effects of your disability we need to be aware?

6. 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) _____

7. Will you be bringing a Personal Care Attendant/Escort with you when you travel?
No _____ Yes _____ (if yes, why?) _____

8. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?
Yes _____ No _____ Sometimes Describe _____

Can you climb three 12-inch steps without assistance?
Yes _____ No _____ Sometimes Describe: _____

Can you wait outside without support for 15 minutes?
Yes _____ No _____ Sometimes Describe: _____

In order to allow Dial-A-Ride to evaluate your request, 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 _____

I hereby certify that the information given above is correct.

Signed _____ Date ____/____/____
(Applicant's signature)

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 MEDICAL VERIFICATION

This section is to be completed by a physician - Please type or 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 by the Federal Transit Administration in order to use this specialized mode of transportation.

What condition or diagnosis do you think the applicant has that restricts their ability to use a public transportation transit system, (i.e. city bus)? _____

Is the 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 ___

Print Name: _____

Address: _____

Office Phone Number _____

Signature: _____

(Physician's Signature)

(License Number)

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

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.

Lower Savannah Council of Governments (LSCOG)
PO Box 850
Aiken, SC 29802
(803) 508-7033

@ 2748 Wagener Road, Aiken, SC 29801

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 Lower Savannah Council of Government's ADTRC at 803-508-7033 Press #1. Your transportation provider will be **Aiken Area Council on Aging, dba Aiken Senior Life Services.**

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 LSCOG. Please call **803-508-7033 Press #1** for Dial-A-Ride with questions or requests for assistance.

OFFICE USE ONLY

DAR Eligible? _____ Card# _____ Effective Date _____

Decision Letter mailed _____ Personal Care Attendant/Escort

Approved _____

Staff Member _____