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 the disability which prevents you from using our fixed route service?____

   ____

   Is this condition temporary? No______ Yes_____
   If yes, how long? ____

5. How does this disability prevent you from using a general (non-specialized) fixed route service? Please explain completely. Use additional paper if necessary.

   ____

   ____

   ____

   ____

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

   ____

   ____

7. 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) _________________

8. Do you need a Personal Care Attendant/Escort when you travel using transit at times?
   No ______ Yes _____ (if yes, why?)_______________________________________

   ____

9. 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, it may be necessary to contact a physician to confirm the information you have provided. 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______________________________

10. I hereby certify that the information given above is correct.

Signed____ Date____/____/____
(Applicant's signature)

11. 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 PROFESSIONAL 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 in order to use the transportation system.

What is the medical diagnosis of the applicant's disability? ______________________________

____

In order to determine the eligibility for the specialized paratransit service, Dial A Ride, how would this medical condition restrict the applicant's ability to use a general (non -specialized) fixed route transit system?

____

____

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____

Does this person need a personal care attendant/escort to help with their mobility at times?

Yes____ No____

Your Name:________________________________ Office Address:____________________
(Print or type)

________________________________ 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 follow the directions on the back of this page.

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 with the transportation provider of Dial-A-Ride services, **GENERATIONS UNLIMITED**.

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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** and ask for the mobility manager 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 ____________________________________ DATE STAMP HERE