DIAL-A-RIDE (DART) APPLICATION AND REQUEST FOR ADA CERTIFICATION

NAME_____

PHONE_____

If you are requesting one of the following:

Demand Response Trips (1st Come 1st Serve Basis On Availability)
OR
Certification For ADA Paratransit Eligibility (Premium Scheduling)

1. **Complete form "REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY", pages 2 and 3.**

AND

2. **Give form "HEALTHCARE PROVIDER CERTIFICATION FOR ADA PARATRANSIT SERVICE", pages 4 and 5 to your doctor to complete and return to Bay Metro.**

PLEASE COMPLETE AND RETURN FORMS TO BAY METRO TRANSIT

MAIL
BAY METRO TRANSIT
ATTENTION: DIAL-A-RIDE
1510 N. JOHNSON St
BAY CITY, MI. 48708

FAX
989-894-2621

E-MAIL
dsmith@baymetro.com

Office Use Only
INELIGIBLE _____ Internally Certified_____
DEMAND-RESPONSE _____
ADA PARATRANSIT CATEGORY: 1._____2._____3._____

MAIL COMPLETED FORM TO: 1510 N Johnson St, Bay City, MI, 48708
FAX TO: 989-894-2621
EMAIL TO: dsmith@baymetro.com
ANY QUESTIONS: 989-894-2900 ext. 3713 or 3716

BAY METRO TRANSIT
REQUEST FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

1. NAME: _____

2. STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

3. TELEPHONE: (HOME): _____ (WORK): _____ (CELL): _____

4. DATE OF BIRTH: ___/___/___

5. What is the disability which prevents you from using fixed route service?

_____

_____

6. Is this condition temporary? ____ If yes, expected duration: ___/___/_____

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

_____

_____

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip request can be made by Bay Metro Transit.

8. Do you use any of the following aids to mobility? (Check all that apply)

Manual Wheelchair _____ Electric Wheelchair _____

Powered Scooter (Amigo) _

Service Animal _____ If service animal is checked, describe type and purpose.

_____

Personal Care Attendant _____
If PCA is checked, does the PCA travel with you all the time? Yes ____ No _____

9. Please answer the following questions:

Can you travel 200 feet (1 block) without the assistance of another person? Yes _____ No___

Can you travel ¼ mile without the assistance of another person? Yes _____ No ____

Can you travel ¾ mile without the assistance of another person? Yes _____ No ____

Can you climb three 12-inch steps without assistance? Yes _____ No ____

Can you wait outside without support for ten minutes? Yes _____ No _____

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

Signed _____ Date: ___/___/_____

In order to allow Bay Metro Transit to evaluate your request, it may be necessary to contact you to arrange an in-person meeting. Bay Metro Transit will contact you to set up the day and time. Transportation will be provided at no cost if this meeting is necessary. Please list the best days of the week and times during the day that you are most often available.

_____

In order to allow Bay Metro Transit to evaluate your request, it may be necessary to contact a physician or other healthcare professional to confirm the information you have provided. Please complete the following information and authorization form.

The following physician and/or healthcare professional is familiar with my disability and is authorized to provide protected information under HIPAA to Bay Metro Transit required to complete this certification for a period of no more than 60 days from the date of my signature below.

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OFFICE TELEPHONE: _____

Applicant Printed Name: _____

Applicant Signature: _____Date: _____

BAY METRO TRANSIT
HEALTHCARE PROVIDER CERTIFICATION
FOR ADA PARATRANSIT SERVICE
[DOCTOR MUST FILL OUT THIS SECTION]

PATIENT'S NAME _____

Your patient has requested eligibility for Bay Metro Transit ADA paratransit service. Bay Metro Transit operates an accessible, fixed-route service; a countywide, demand-response service for seniors and disabled (first-come-first-serve); and an ADA Paratransit service for those individuals that have a disability which specifically prevents them from using the fixed route service and obligates Bay Metro Transit to transport them under Federal ADA guidelines. If the individual is disabled but is capable of riding the fixed route, they may still ride the demand-response service, but may not qualify for ADA Paratransit service.

As the applicants healthcare provider you are uniquely qualified to clarify his or her functional abilities and limitations to ride Bay Metro Transit's fixed route service. In order to determine this applicant's functional abilities, please complete and certify to the following questions. Please be as detailed as possible as to how the applicant's disability impacts their ability to board, navigate, and travel on the fixed route system. We do not need to know exact diagnosis, just its impact on the applicant's abilities.

1. NAME OF HEALHCARE PROVIDER: _____

2. STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

3. OFFICE TELEPHONE: _____ 4. SPECIALIZATION: _____

5. Is the applicant's disability/condition temporary? _____ If yes, what is the expected duration:
_____/____/____/_____

6. Does the applicant require the use any of the following aids to mobility? (Check all that apply)

Manual Wheelchair _____ Electric Wheelchair ____ Powered Scooter (Amigo) ____

Service Animal _____ If service animal is checked, describe type and purpose _____
_____

Personal Care Attendant _____ If PCA is checked, does the PCA have to travel with the applicant all the time? Yes ___ No _____

7. If the applicant is currently on medications, will the side effects of this reduce or hinder this applicant's ability to use the accessible fixed route service? Yes _____ No

8. Please answer the following questions:

Is the applicant able to travel 200 feet (1 block) without the assistance of another person? Yes __ No __

Is the applicant able to travel ¼ mile without the assistance of another person? Yes ___ No __

Is the applicant able to travel ¾ mile without the assistance of another person? Yes ____ No __

Is the applicant able to climb three 12-inch steps without assistance? Yes ____ No _____

Is the applicant able to wait outside without support for ten minutes? Yes ____ No_____

Is the applicant any more susceptible to the affects of heat than an individual without the applicant's disability/condition?
Yes _____ No _____

Is the applicant any more susceptible to the affects of cold than an individual without the applicant's disability/condition?
Yes _____ No _____

Is the applicant any more susceptible to the affects of air quality than an individual without the applicant's disability/condition?
Yes _____ No _____

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

_____

_____

10. In your professional assessment, HOW does the applicant's disability or condition impact their ability to travel independently from one location to another on Bay Metro Transit's fixed route service? _____

_____

_____

_____

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

Signed _____ Date: ___/___/_____

PLEASE FAX COMPLETED FORM TO BAY METRO TRANSIT AT:
989-894-2621
IF YOU HAVE ANY QUESTIONS, PLEASE CALL:
989-894-2900 ext. 3713 or 3716