# DIAL-A-RIDE
## PARATRANSIT
## APPLICATION


Ben Franklin Transit (BFT) has proudly offered Dial-A-Ride (DAR) paratransit service throughout the Tri-Cities community for over 40 years. Dial-A-Ride drivers provide door-to-door transportation to clientele with disabilities that prevent them from utilizing the regular fixed-route bus system.

To see if you or a loved one qualifies, please complete and submit this application to BFT Dial-A-Ride staff, who will evaluate it using criteria established by the Americans with Disabilities Act (ADA) within 21 calendar days of receipt. Once your application has been evaluated, you will receive a decision letter via U.S. mail. If your application is denied, the letter will contain information about how to appeal the decision.

# DIAL-A-RIDE
## APPLICATION CHECKLIST

Transit
BEN FRANKLIN TRANSIT

To be considered for BFT Dial-A-Ride paratransit service, you must complete this application in its entirety. **Incomplete applications will be returned.**

Additionally, an in-person functional assessment may be required. If you have any questions or need assistance completing this application, **please call 509.735.0160.**

## CHECKLIST & INSTRUCTIONS

- [ ] Complete pages 1-6. Answer all questions and thoroughly explain how your disabilities prevent you from using the regular bus system.
- [ ] Ensure the application form is signed on **page 6** and names are printed clearly. If you are under the age of 18, your parent or legal guardian is required to sign the application. If your Legal Guardian or Power of Attorney (POA) is signing the application, please attach current Legal Guardian/POA documentation.
- [ ] Please ensure that a licensed healthcare provider/physician has reviewed the entire application and completed the Verification Form (**pages 7-8**), which must be returned with this application. This form must be completed by one of the following:

*Medical Doctor (MD or DO) / Licensed Mental Health Professional / Optometrist or Ophthalmologist / Physical or Occupational Therapist / Psychologist (Ph.D.) / MDS Nurse (Skilled Nursing Facilities ONLY) / Physician's Assistant or ARNP*

***Once completed, please send all pages of this application:***

- Via fax to 509.734.5195
- U.S. mail to:
  - ⇨ Dial-A-Ride Eligibility
    1000 Columbia Park Trail
    Richland, WA 99352
- In person to:
  - ⇨ 7109 W. Okanogan Place,
    Kennewick, WA 99336 or
  - ⇨ 1000 Columbia Park Trail
    Richland, WA 99352

*Applications are considered complete when all questions have been answered and all signatures and contact information of professional sources have been provided, including Legal Guardian/POA documents, if applicable.*

# APPLICATION FOR DIAL-A-RIDE SERVICE

Transit
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## INSTRUCTIONS

On pages 1-6 of this application, BFT asks for information about you, your mobility, and your ability to use fixed-route bus service. Please answer ALL questions carefully and completely. A friend, guardian, agency service representative, or family member may help you. We cannot determine your eligibility for Dial-A-Ride service without this information.

**Pages 7-8 must be completed by a certified physician/certified health professional who is familiar with your impairment or condition.** If you have any questions, please call Dial-A-Ride Customer Service at 509.735.0160.

Have you ever applied for Dial-A-Ride service? ☐ Yes ☐ No

If yes, Client ID#_____

| | | | |
|---|---|---|---|
| Name of Applicant/Last | First | Middle | Male ☐ Female ☐ Prefer not to answer ☐ |
| Address | Apartment # | City | Zip Code |
| Date of Birth (Optional) / / | Home Phone Number | Other Phone Number | |
| Apartment Complex Name | | | Gate Code |
| MailingAddress (If different than home address) | Apartment # | City | Zip Code |
| Preferred Language | Are you a U.S. Veteran? (Optional) Yes ☐ No ☐ | | Arc Participant? Yes ☐ No ☐ |
| Name of Emergency Contact | Relationship | Emergency Phone | |

# Application for Dial-A-Ride Service
# CONDITIONS/MOBILITY AIDS

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## PLEASE CHECK ALL CONDITIONS THAT APPLY TO YOU:

- ☐ Amputation
- ☐ Autism
- ☐ Balance Problems
- ☐ Blind or Low Vision
- ☐ Brain Injury
- ☐ Breathing Condition
- ☐ Cognitive Disability
- ☐ Confusion
- ☐ Deaf or Hearing Impairment
- ☐ Dialysis Required
- ☐ Frail
- ☐ Memory Loss
- ☐ Nonverbal
- ☐ Obesity
- ☐ Pain
- ☐ Panic
- ☐ Paralysis
- ☐ Psychosis
- ☐ Seizures
- ☐ Significant Limitation of Activity

## WHEN YOU TRAVEL OUTSIDE YOUR HOME, WHICH MOBILITY AIDS DO YOU NEED? (Check all that apply.)

- ☐ None
- ☐ White Cane
- ☐ Service Animal
- ☐ Support Quad Cane
- ☐ Walker
- ☐ Portable Oxygen
- ☐ Powered Wheelchair
- ☐ Manual Wheelchair
- ☐ Cane
- ☐ Powered Scooter
- ☐ Personal Care Attendant (PCA)
- ☐ Other (Please specify below)

_____

_____

_____

# Application for Dial-A-Ride Service
# INDIVIDUAL & MOBILITY INFORMATION

Transit
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1. Please state your disability(ies): _____

   _____

   _____

2. What is the street intersection nearest your home? (***Example East 27th @ South Oak***)

   _____

3. Can you walk or use your wheelchair or other assistive device(s) to get from your home to that intersection without assistance? ☐ Yes ☐ No
   If no, please explain: _____

4. Can you find your way to a bus stop without getting lost? ☐ Yes ☐ No
   If no, please explain: _____

5. How long can you stand and wait for a bus?
   ☐ 15 minutes ☐ 10 minutes ☐ 5 minutes ☐ Less than 5 minutes

6. Do you currently ride the regular fixed-route buses?
   ☐ Yes ☐ No
   Please explain: _____

   _____

7. All buses have a 'destination sign' in front which shows the route name and number.
   Can you read a bus destination sign? ☐ Yes ☐ No
   Can you ask the driver where the bus is going? ☐ Yes ☐ No
   Can you give or write a note to the driver? ☐ Yes ☐ No
   Can you understand the driver's answer? ☐ Yes ☐ No
   If no to any questions, please explain: _____

   _____

   _____

8. If you were on a bus, could you pay the fare by putting money in the fare box?
   ☐ Yes ☐ No: If no, please explain: _____

# Application for Dial-A-Ride Service
# INDIVIDUAL & MOBILITY INFORMATION

Transit
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9. If you were on the regular bus, could you recognize where you needed to get off?
☐ Yes ☐ No
If no, please explain: _____

10. Please tell us about the situations when you **can** use BFT's regular fixed-route bus service. (Examples: If it is a short distance to the bus stop; with an attendant; when I need to get somewhere the same day): _____
_____

11. Have you ever received Orientation and Mobility Training (Travel Training)?
☐ Yes ☐ No
If yes, please list which BFT routes you learned to travel: _____

12 a. Please tell us why you **cannot** use BFT's regular fixed route bus service for some or all trips. (Examples: Surgery, injury, weather, fatigue--conditional)
_____
_____

12 b. If you face challenges that prevent you from using fixed routes, please tell us what kinds. (Examples: No sidewalks in area; no accessible bus stops)
_____
_____

13. How do you currently travel? (Examples: Self, family, friends, bus, Dial-A-Ride)
_____

14. Do you require someone to travel with you? ☐ Yes ☐ No
If yes, please explain: _____
_____

15. Can you wait independently or alone at your residence and places to which you travel? ☐ Yes ☐ No
If no, please explain: _____
_____

# Application for Dial-A-Ride Service
# INDIVIDUAL & MOBILITY INFORMATION

Is there anything about your disability/limiting condition that may help us better understand your travel abilities and limitations?

_____

_____

_____

_____

_____

_____

_____

_____

_____

## DID YOU KNOW?

Ben Franklin Transit offers free training to learn how to ride the local bus routes. Participation in travel training will not affect your Dial-A-Ride eligibility. Are you interested?

☐ Yes (A BFT employee will contact you soon.)
☐ No

If no, please explain: _____

_____

_____

# Application for Dial-A-Ride Service
# AGREEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this application, you authorize the release of information to Ben Franklin Transit or its representatives to evaluate your eligibility for Dial-A-Ride service using the information you provided in this application.

Ben Franklin Transit may share your eligibility determination with other transportation providers, upon request, to facilitate travel in other transit districts.

This form must be signed by the applicant or, if applicable, by the applicant's Legal Guardian or Power of Attorney. If the applicant is under 18 years of age, a parent or Legal Guardian must sign this form. **If a Legal Guardian or Power of Attorney will be signing this form, the following attachments are required:**

☐ Legal Guardian: Copies of current Letters of Guardianship and the Order Appointing Guardian document from the court

☐ Power of Attorney: Current documentation that grants the Power of Attorney the right to sign a medical release form on behalf of the applicant

*I **HEREBY CERTIFY,** under penalty of perjury, under the laws of the State of Washington, that the information provided on this form is true and correct.*

Signature (*required*) _____ Date:_____

☐ Applicant ☐ Legal Guardian (include attachment)

☐ Power of Attorney (include attachment)

Name (applicant) _____ Phone: ( ____ ) _____

***If a Legal Guardian or Power of Attorney completed this form, please complete the following (please print):***

Name _____ Phone: ( ____ ) _____

Relationship to Applicant _____

# Application for Dial-A-Ride Service
# LICENSED HEALTHCARE PROVIDER/ PHYSICIAN VERIFICATION FORM

## Applicant Name: _____

**Please ensure that a licensed healthcare provider/physician who is familiar with the applicant has reviewed the entire application prior to completing this form.**

We need your assistance in determining eligibility for Dial-A-Ride services for the applicant named above. We are seeking information regarding the limitations this applicant faces in using bus service for local transportation. BFT's buses are equipped with ramps, lifts, and kneeling features to assist with boarding, as well as automatic announcements of major stops to help riders know where they are along the route.

The information you provide in the following sections will be used to help determine the applicant's Dial-A-Ride eligibility. It is important that all questions are answered completely and accurately to the best of your knowledge and in accordance with your records. If the information is incomplete or unclear, we may contact you for clarification. Thank you for your cooperation.

**Have you previously seen this patient?** ☐ Yes ☐ No

**Please review the information provided by the applicant. Based on your knowledge of the applicant's condition, is the information accurate?**

☐ **Yes** ☐ **No** ☐ **Somewhat**

**If you checked "No" or "Somewhat," please explain:**_____

_____

| DIAGNOSIS/DISABILITY (not symptoms) | DEGREE OF IMPAIRMENT (circle one) | DATE OF ONSET |
|---|---|---|
| _____ | **Mild Moderate Severe** | _____ |
| _____ | **Mild Moderate Severe** | _____ |
| _____ | **Mild Moderate Severe** | _____ |
| _____ | **Mild Moderate Severe** | _____ |
| _____ | **Mild Moderate Severe** | _____ |

**Is the applicant receiving treatment for the above disabilities?** _____

**Is the applicant's need for Dial-A-Ride service permanent or temporary?**

☐ **Permanent** ☐ **Temporary - How Long:**_____

# Application for Dial-A-Ride Service
# LICENSED HEALTHCARE PROVIDER/ PHYSICIAN VERIFICATION FORM

**Please rate the applicant's abilities while using their mobility aid in terms of:**

| | Excellent | Good | Fair | Poor | None | Don't Know |
|---|---|---|---|---|---|---|
| A. Upper Body Strength | | | | | | |
| B. Lower Body Strength | | | | | | |
| C. Coordination | | | | | | |
| D. Balance | | | | | | |
| E. Self-Awareness | | | | | | |
| F. Independent Judgment | | | | | | |
| G. Sense of Direction | | | | | | |
| H. Ability to Understand and Follow Instructions | | | | | | |
| I. Verbal Communication | | | | | | |
| J. Written Communication | | | | | | |
| K. Stamina and Endurance | | | | | | |

**If visually impaired, what is the applicant's best corrected acuity?**
**Date of Testing: _____ (Snellen?) (R) _____ (L) _____**
**Field Restriction: (R) _____ (L) _____**

## PHYSICIAN OR HEALTHCARE PROFESSIONAL'S CERTIFICATION

*I certify that the information I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that Dial-A-Ride staff may contact me for clarification of any information I have provided, and that I will reply in good faith.*

**Healthcare Professional's Full Name: _____**

**Institution/Facility/Agency Name:_____**

**Area of Specialty: _____**

**Street Address: _____ Suite #: _____**

**City: _____State:_____Zip Code: _____**

**Phone:_____Fax: _____**

**Healthcare Professional's Signature: _____ Date _____**