DIAL-A-RIDE APPLICATION

PLEASE READ THIS SECTION BEFORE YOU BEGIN

CCAT provides door to door service also known as Dial-A-Ride to people who are:
1) Disabled and unable to use the deviated fixed route
2) Over 60 and unable to use the deviated fixed route
3) Students in 9th – 12th unable to use the deviated fixed route and using a pre-paid pass or ticket

This application intended to determine when and under what circumstances the applicant can use the deviated fixed route buses and when dial-a-ride service in required.

Instructions – The applicant (or someone assisting them) must complete PAGES 1- 4. The applicant must sign the application. A professional must complete and sign the professional verification section (page 5). In addition, an in-person interview with CCAT staff may be scheduled to determine eligibility. Information regarding the CCAT Dial-A-Ride program is available in the Riders Guide at www.coostransit.org. If you have any questions about completing this application, call CCAT at (541)267-7111. Hearing impaired can call 7-1-1 for assistance.

INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT.

When completed, return the entire form to:

Mail To:  Coos County Area Transit
         2810 Ocean Blvd
         Coos Bay, OR 97420

Fax:   (541) 982-5381
Coos County Area Transit  
2810 Ocean Blvd  
Coos Bay, OR  97420  
Office: (541)267-7111   Fax: (541) 982-5381 www.coostransit.org

DIAL-A-RIDE Application Form

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Address</td>
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<td>City</td>
<td>State</td>
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<td></td>
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<tr>
<td>Home Phone</td>
<td>Work Phone</td>
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Emergency contact name

Emergency contact number

Which of the following mobility aids (supplied by you) do you use when traveling?

A  □ Motorized wheelchair  □ Scooter  □ Manual wheelchair
   Dimensions of wheelchair or scooter

B.  □ Cane  □ Walker  □ Crutches

C.  □ Oxygen

D.  □ Service Animal  Type of Animal

E.  □ Personal Care Attendant (PCA)-someone designated by you to assist you with one or more daily life functions and as necessary with your mobility.

F.  □ None of the above

Date of Birth Age Male □ Female □ Other □

Are you a student in 8th to 12th grade? □ Yes □ No
If yes, what school

Can you use the bus stop nearest your home? □ Yes □ No
If no, why not? (Example: no shelter, no curb cut, no bench, etc.)
How far, in city blocks, is the nearest bus stop to your home? _____________________________

Please check a box for each question:  
Always  Never  Sometimes

a. I can ride CCAT buses by myself (without assistance from someone other than the driver)
□  □  □
b. I need a lift to board the bus
□  □  □
c. I can walk (or travel with my mobility device) to the bus stop
□  □  □
d. I could probably ride the regular bus with some training
□  □  □

Please explain any box checked “Sometimes”
_____________________________________________________________________________

Have you ever ridden a regular CCAT bus?  □ Yes  □ No

Have you ridden a regular CCAT bus in the past 6 months?  □ Yes  □ No If yes, how many times a month do you ride?  _____________________________

What bus route(s) do you usually ride?  ________________________________________________

DISABILITY INFORMATION

1. Are you able to complete the following tasks without assistance from another person? (Check a box for each question.)

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Never</th>
<th>Sometimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Get to/from the bus stop?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Walk (or travel using mobility device) five blocks?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Get on/off a regular bus without using a lift?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>d. Get on/off a regular bus using a lift?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>e. Climb three 10 inch steps?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>f. Wait at a bus stop for 30 minutes?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>g. Maintain your balance entering, exiting and riding a regular bus?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>h. Understand and follow verbal directions?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>i. Recognize correct stops and landmarks to complete a trip?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>j. Hear stops announced by the driver?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>k. Read and understand informational signs?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>l. Plan a trip using public transportation?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>m. Communicate information about yourself?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Please explain any boxes checked “Sometimes”

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

1. What is your disability?
   □ Visual Impairment ____________________________________________
   □ Mobility Impairment ____________________________________________
   □ Cognitive/Psychological ____________________________________________
   □ Cardiovascular/Respiratory ____________________________________________
   □ Other ____________________________________________

2. If you have visual impairment, please check each box that describes your disability
   □ Totally blind □ light perception
   □ severely blurred/distorted vision □ night blindness
   □ mildly blurred/distorted vision □ severe glare sensitivity
   □ Central visual field loss □ tunnel vision
   □ Half field loss □ loss of depth perception
   □ Other ____________________________________________

3. How does your disability prevent you from using a regular lift-equipped bus?
   ______________________________________________________________________
   ______________________________________________________________________

4. Is your disability (check one) □ permanent □ temporary until ________________ □
   Episodic (please describe) ______________________________________________________________________

5. Do you have other health problems that CCAT needs to be aware of? (Examples: shortness of
   breath, seizures, dizziness, muscle weakness, fatigue, lack of coordination, etc.)
   ______________________________________________________________________
   ______________________________________________________________________
6. In city blocks:
   a. How far can you walk? __________________________________________
   b. If you use a wheelchair or scooter, how far can you travel in blocks?
   ________________________________________________________________

7. Is your ability to walk (or travel using a mobility device) affected by weather?
   □ No  □ Yes explain:______________________________________________

8. Is your ability to walk (or travel using a mobility device) affected by terrain?
   □ No  □ Yes explain:______________________________________________

A.  APPLICANT CERTIFICATION

I certify that the information I provided in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services that I request will be disclosed to those who perform those services.

Applicant Signature: __________________________________________________________

Date: ___________________________________________

B.  PERSON COMPLETING FORM IF OTHER THAN APPLICANT
   (Please check one):

   I certify that the information provided in this application is true and correct, based on information given me by the applicant.

   I certify that the information provided in this application is true and correct, based on my own knowledge of the applicant’s health, disability or condition.

   Signature_______________________________________ Date________________________

   Name _________________________________________ Phone_________________________

   Address _____________________________________________________________________

   City ___________________________ State_________ Zip_______________

   Relationship to Applicant_______________________________________________________
PROFESSIONAL VERIFICATION

This page MUST be completed by one of the following

___ Vocational Rehabilitation Counselor ___ Psychiatrist
___ Special Education Teacher ___ Physician’s Assistant
___ Physician ___ Physical Therapist
___ Respiratory Therapist ___ Occupational Therapist
___ Registered Nurse ___ Nurse Practitioner
___ Chiropractor ___ Social Worker
___ Travel Trainer ___ Other (Describe)

Patient/Client Name ________________________________

Please describe conditions preventing the applicant from using deviated fixed route services:
________________________________________________________________________________________
________________________________________________________________________________________

Is this condition temporary? ____ Yes, for ________ weeks/months  ____ No

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature _______________________________ Date __________________

Print Name _______________________________ Daytime Phone___________

Clinic/Agency _____________________________

Address __________________________________________