



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 is 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

Last Name _____ First _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

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? _____ 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	I need a lift to board the bus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	I can walk (or travel with my mobility device) to the bus stop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	I could probably ride the regular bus with some training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.)

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

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
- severely blurred/distorted vision
- mildly blurred/distorted vision
- Central visual field loss
- Half field loss
- Other _____
- light perception
- night blindness
- severe glare sensitivity
- tunnel vision
- loss of depth perception

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 _____