Dial~A~Ride Application

The information obtained in this certification process will be utilized for the provision of transportation services. This agency will not share your application with other transportation agencies or providers unless you request us to do so.

If you need help completing this application, please call Pullman Transit at 332-5471, or TDD Relay (800) 833-6388 or 7-1-1.

Name______________________________Birth Date __________

Street Address____

Home Phone __________________Work Phone ______________

E-Mail Address____

Are you a WSU student/staff/faculty/retiree? _________________

I certify that the information I gave in this application is true and correct. Falsification of information may result in denial of service. I understand all healthcare information will be kept confidential except as needed for verification. Only the information required to provide services I request will be disclosed to those who perform those services. I have read and agree to comply with the policies and procedures set forth by Pullman Transit. I understand this document is a public record and may be subject to disclosure under RCW 42.17 upon request.

Applicant Signature_________________________Date_________

(If Applicant is a minor, or incapable of signing this application, please complete page 5)

Are you interested in applying for Americans with Disabilities Act certification through Pullman Transit? (Please read through the accompanying information on the ADA for clarification. If you have any question regarding the ADA, please call Kristina at 338-3249) NO_____ YES_____

Have you applied for or been certified through another agency? NO_____ YES_____ If yes, please list the agency and your certification number:_________________________________

Please refer to the accompanying material on the ADA for additional information. If you choose not to apply for ADA certification at this time, you may request this information from Pullman Transit at any time.

From the following list please check any condition or disability that prevents you from using the fixed route bus service:

___General Medical Conditions

__None __Kidney Failure/Dialysis __Diabetes __Immunity Suppression
__Cancer Treatment __Other____

___Heart and Circulatory Conditions

__None __Peripheral Vascular Disease __Stroke __Edema __Heart Attack
__Congestive Heart Failure __Heart Surgery __Other________________________

___Lung and Breathing Conditions

__None __Emphysema __Asthma __Lung Cancer __Cystic Fibrosis
__Chronic Obstructive Pulmonary Disease __Other_________________________

___Vision/Hearing/Speech Conditions

__None __Dysarthria __Blind __Aphasia __Cataracts __Night Blindness __Deaf
__Glaucoma __Partially Sighted __Hearing Impaired
__Diabetic Retinopathy __Other____

___Developmental/Mental/Behavioral Conditions

__None __Inability to Communicate/Nonverbal __Autism
__Learning Disability Explain____
__Mental Disability: ☐Mild ☐Moderate ☐Severe
__Short Term Memory Loss
__Thought Disorder/Confusion Explain_________________________________
__Aggressive toward: ☐Property ☐Other People ☐ Self ☐Verbal Only
Explain____
__Difficulty Controlling Behavior, Explain_________________________________
__Mood Disorder, Explain____
__Phobia or Phychosis, Explain____

___Bone and Joint Conditions

__None __Arthritis __Rheumatoid Arthritis __Osteo-Arthritis __Osteoporosis __Fusion __Hip Disarticulation __Scleroderma __Prosthesis __Dwarfism __Broken Bone: Location____
__Amputation: Location____
__Other____

___Brain/Nerves/Muscle Conditions

__None __Alzheimer's Disease __Amyotrophic __Brain Injury _Cerebral Palsy __Dementia __Epilepsy/Seizures __Friedreich's Ataxia __Gullian-Barre __Huntington's Chorea __Lateral Sclerosis __Multiple Sclerosis __Muscular Dystrophy __Parkinson's Disease __Post-polio __Quadriplegia __Spina Bifida __Vertigo/Dizziness __Other___________________________

Please explain as completely as possible how your disability prevents you from boarding, riding and exiting a regular fixed route bus.____
____
____

How would you best describe your disability or condition as it impacts your transportation needs?

___Permanent ___Deteriorating ___Changeable ___Temporary

If temporary, until what date______________________________

Are there other effects of your disability or condition that we need to be aware of in order to provide you with appropriate service?

____
____
____

Which of these aids or equipment do you usually use to help you get where you need to go?

___Cane ___Manual Wheelchair ___Service Animal
___White Cane ___Electric Wheelchair ___Power Scooter
___Crutches ___Walker ___Other_______
___Oxygen ___Personal Care Attendant

Do you ever need the assistance of another person to be able to travel on Pullman Transit, either on the bus or Dial~A~Ride?
___Yes ___No ___Sometimes

When do you need help?
___Getting to/from vehicle ___Getting on or off the vehicle

What is the longest distance you can walk/travel on level ground without the assistance of another person? (Example 370 feet = 1 block)____

Can you travel this distance in snow, ice, and uneven or steep ground?
___Yes ___No ___Sometimes, please explain:______________

Please provide the name address and phone number of a doctor, health care professional or rehabilitation professional who is familiar with your condition or disability and can verify the information contained in this application.

Name____

Address____

City, State, Zip____

Phone_______________________ Fax Number______________

I hereby certify that the information given above is correct. I authorize Pullman Transit to contact the person named above to verify this information.

____

Signature of Applicant Date

If someone has completed this application other than the person applying for certification, that person must complete the following:

☐ I certify that the information provided in this application is true and correct based upon my knowledge of the applicant's health condition or disability.

☐ I certify that the information provided in this application is true and correct based upon information given to me by the applicant.

Signature_________________________________Date____________

Print Name________________________Daytime Phone___________

Address____

Relationship to Applicant____________________________________

Local Contact Person

This is a person who is authorized to make day-to-day and/or emergency decisions regarding service for the applicant. (In most cases this will be a provider or family member)

Name____

Address____

City, State, Zip____

Daytime Phone_______________________Evenings______________

Relationship____