PASADENA DIAL a RIDE

Transportation Service for Seniors & Persons with Disabilities

DIAL-A-RIDE APPLICATION

Mail or deliver application to:
PASADENA DIAL-A-RIDE
221 East Walnut Street, Suite 199, Pasadena, CA 91101

Code:

Please Check One:

❑ **New Application**

❑ **Renewal**

❑ **Lost Card**

Office Use Only

Submit the following to process your DIAL-A-RIDE membership:

1) Completed Application
2) Copy of identification with your date of birth and residential address
3) Physician's Verification (only if under 60 years old)

IF YOU ARE UNDER 60 YEARS OF AGE YOU MUST HAVE YOUR PHYSICIAN COMPLETE THE PHYSICIAN'S VERIFICATION ON THE BACK SIDE VERIFYING THAT YOU ARE NOT ABLE TO USE REGULAR FIXED ROUTE TRANSIT BUSES (METRO, ARTS, FOOTHILL TRANSIT, ETC) -OVER-

Name: _____ Date of Birth: _____ ❑ Male ❑ Female

Address: _____ Apt. #: _____ Zip Code: _____

City: ❑ Pasadena ❑ Altadena ❑ San Marino ❑ Unincorporated L.A. County (within our service area only)

Type of Residence: ❑ Individual ❑ Retirement/Senior Home ❑ Board & Care

Name of Living Facility (if applicable): _____ Phone No.: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Age: ❑ 60+ ❑ Under 60 (with a disability that prohibits use of regular fixed route transit buses) Legally blind: ❑ Yes ❑ No

Disabled: ❑ No ❑ Yes (explain) _____

_____

Do you have an Access Services card? ❑ Yes ❑ No

I use the following: ❑ Walker ❑ Manual wheelchair ❑ Electric wheelchair ❑ Service animal

I speak: ❑ English ❑ Spanish ❑ Chinese ❑ Japanese ❑ Armenian ❑ Other

Do you require a self-provided escort? ❑ Always ❑ Sometimes ❑ Not Required

EMERGENCY CONTACT INFORMATION:

Contact: _____ Relationship: _____ Phone: _____

I assume full responsibility for and release the City of Pasadena, the City of San Marino,and Los Angeles County from any liability for my safety and well-being before I board and after I exit the DIAL-A-RIDE vehicle.

SIGNATURE: _____ DATE: _____

Statistical Information - For funding purposes

This information is voluntary. Please check one box only that you most closely identify with:

❑ Asian or Pacific Islander ❑ Native American or Alaskan Native

❑ Black (non-Hispanic) ❑ White (non-Hispanic)

❑ Hispanic ❑ Armenian

For Administration Purposes Only

Date Mailed _____ Processed By _____

Comments _____

_____

_____

PHYSICIAN'S VERIFICATION – Part II of Application (Only for disabled applicants under 60 years old)

This section must be completed by an authorized California Physician

Eligibility Evaluation

Applicant's Name: _____ Date of Birth: _____

Indicate one or more of the following disabilities that prohibits the applicant from boarding and alighting regular public transit:

❑ Legally blind ❑ Kidney disease ❑ Developmentally Disabled

❑ Impaired by class III or class VI type cardiovascular disease as defined by the American Heart Association

❑ Suffers from lung disease such that measured forced respiratory volume for one second is less than 1L orarterial oxygen tension is less than 60 mm/Hg on room air at rest

❑ Other. Explain disabilities (in detail): _____

_____

_____

Does patient have an Access Services card? ❑ Yes ❑ No

Duration and Degree of Disability: This service is intended for people who CANNOT use regular public transportation (fixed route buses)

The patient's disability is: ❑ Permanent ❑ Temporary

If temporary, please indicate the length of disability:

❑ 2 months ❑ 4 months ❑ 6 months (*After 6 months, physician's re-verification is required)

Does the applicant require a self-provided escort? ❑ Always ❑ Sometimes ❑ Not Required

Physician's Information:

Physician's Name: _____ License No.: _____

Business Address: _____

City: _____ St.: _____ Zip: _____ Phone: _____

I hereby certify that I am a licensed physician of the State of California, have knowledge of this applicant, and recommend that the applicant be certified to use the Pasadena, San Marino, Los Angeles County DIAL-A-RIDE because of the aforementioned disability **which prevents the applicant from using regular fixed route transit buses** (Example: Metro, ARTS, Foothill Transit, etc.).

What prevents the applicant from using regular transit services? (must be filled out by physician)

_____

_____

Physician's Signature: _____ Date: _____

- Please fill out all blank lines and check all boxes that pertain to your application.
- If you have any questions call the DIAL-A-RIDE administrative office at (626) 744-4094

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