City of Madera Transit Services
Dial-A-Ride (DAR)
Paratransit Application/ ADA Certification Form

Madera Transit Center
1951 Independence Drive
Madera, Ca. 93637

Name:____Date of Birth:_/____/_____
First Middle Last Mo
Day Year

Address:____
Street City
State Zip

Mailing Address (if different from above) _______________________________________

Phone Number:__________________ Alternative Phone Number __________________

Email:____

Do you require future information to be provided in an alternative format? ☐ Yes ☐ No

If yes, please specify. ☐ Large Print ☐ Audio Tape ☐ Braille ☐ TTY/TDD

Are you able to independently get to and from a regular Madera Metro fixed-route stop?
☐ Yes ☐ No

Are you able to get independently on and off a Madera Metro transit vehicle without assistance?
☐ Yes ☐ No

Are you restricted to a wheelchair? ☐ Yes ☐ No If yes, is it motorized? ☐ Yes ☐ No

Do you use a mobility devise such as a cane or a walker? ☐ Yes ☐ No

Will you be traveling with a personal care attendant? ☐ Yes ☐ No

Will you be traveling with a rider companion? ☐ Yes ☐ No

Will you be traveling with a service animal? ☐ Yes ☐ No

What type of transportation do you currently use?

☐ Drive self/ private auto
☐ Madera Metro Fixed Route
☐ Walk
☐ Friend/ Family Member
☐ Tax
☐ Other____________________________

Do you have any difficulty in understanding how to use or navigate through the City Transit Service system? ☐ Yes ☐ No

Can you climb steps without the assistance of another? ☐ Yes ☐ No

Please provide an emergency contact?

Name_______________________________________ Relationship___________________

Address____

City, State, Zip____

Phone Number____

AGREEMENT AND AUTHORIZATION

I certify that the information in this application is true and correct. I understand that falsification of the information may result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services. I agree to abide by the rules and procedures of the City of Madera Transit Services Dial-A-Ride Program.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

Applicant's Signature_____________________________ Date_____________

I hereby authorize the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition, to release this information to my local public transit agency. This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Applicant's Signature______________________________ Date__________________

Name of Licensed Professional who may release my medical information:

Name: ____

Address: ____

Phone Number: (   )_____ - _____________

LICENSE PROFESSIONAL’S STATEMENT OF ADA ELIGIBILITY

Print Applicant’s Name: ________________________________

The Americans with Disabilities Act of 1990 requires Local Transit Operator to provide Paratransit services to individuals who, because of their medical condition or impairment are prevented from using fixed route buses. Economic status, and environmental conditions may not be considered “medical” factors in the assessment of paratransit eligibility. The information requested of you in the following sections will be used to determine the applicants' ADA eligibility. It is important that all questions be 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 need to contact you for clarification. Thank you for your cooperation.

THIS SECTION TO BE COMPLETED BY ONE OF THE FOLLOWING:

☐Physician ☐Chiropractor ☐Health Care Provider ☐Physical Therapist

☐Rehabilitation Counselor ☐Other Licensed Professional_________________________

Is the applicant disability permanent?
( ) Yes
( ) NO
If NOT, HOW LONG do you expect disability to last? ________________________

NOTE: If a disability is temporary, it must last for at least 90 days to be eligible for ADA Paratransit Services.

Please provide Formal Medical Diagnosis to describe the applicant’s primary impairments or disabling conditions: (NOTE: WITHOUT THIS DIAGNOSIS CERTIFICATION WILL BE DENIED)
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____
____
____

______________________________ ______________________________
License Professional’s Name Printed License’s Professional’s License # (REQUIRED)

____
Signature (MUST BE AN ORIGINAL, — Copies, Faxes, and /or Stamped NOT ACCEPTED)

Date ___________________