Dial-A-Ride

Eligibility & Checklist Application

Thank you for your interest in Ben Franklin Transit's Dial-A-Ride paratransit service.

If you are seeking eligibility for service, you must complete the entire application process. Additionally, an in-person functional assessment may be required.

Please be sure to print this form out double-sided. If you have any questions, or if you need assistance completing this application, please call us at 509.735.0160.

CHECKLIST & INSTRUCTIONS

All 9 pages of this application must be completed and returned at the same time. Before submitting this application form, please:

- ☐ Complete pages 1-9 of this application ***in entirety.***
- ☐ Ensure the application form is signed on page 6. Please print clearly. If you are under age 18, your parent or Legal Guardian is required to sign the application. If you have a Power of Attorney, he or she is also required to sign this application.
- ☐ Ensure that the Licensed Healthcare Provider or Physician Verification Form (page 9), has been completed by a medical provider and is included in this application. ***This form must be completed by one of the following:***

  Medical Doctor (MD or DO) | Licensed Mental Health Professional | Optometrist or Ophthalmologist | Physical or Occupational Therapist | Psychologist (Ph.D.) | MDS Nurse (Skilled Nursing Facilities ONLY | Physician's Assistant or ARNP

Once completed, please send all pages of this application to:

By mail at: BEN FRANKLIN TRANSIT
ATTN: Dial-A-Ride
7109 W. OKANOGAN PLACE
KENNEWICK, WA 99336

Or by fax at: 509.734.5195

Application for Dial-A-Ride Service

INSTRUCTIONS

On pages 1-5 of this application, Dial-A-Ride is asking for information about you, your mobility and your ability to use Ben Franklin Transit's fixed route bus service. Please take the time to answer ALL questions carefully and completely. We cannot determine your eligibility for Dial-A-Ride service without this information. A friend, guardian, agency service representative or family member may help you complete your portion of the application (pages 1-6). Accurate information is required about you, your medical impairment and your functional capacity. Pages 7-9 must be completed by a certified physician/certified health professional who is familiar with your impairment or condition.

If you have any questions, please call Dial-A-Ride Customer Service at 509.735.0160.

Have you ever applied for Dial-A-Ride service? No ☐ Yes ☐

Name of Applicant Last/Appellido Nombre de Solicitante	First/Nombre	Middle/Inicial	Social Security Number (last 4 digits) Numero del Seguro Social del Solicitante (los ultimos 4 numeros) XXX - XX -
Address/Street Dirección/Calle	Apartment Numero de Apartmento	City/Cuidad	Zip Code/Codigo Postal
Date of Birth Fecha de Nacimiento	Home Phone Number/En Casa Número de Teléfono	Other Phone/Otro Teléfono	
Apartment Complex Name/Nombre de Apartmentos			Gate Code/Codiga de Cochera
Mailing Address/Dirección de Envio If different than home address/Si differente de domocilio	City/Cuidad		Zip Code/Codigo Postal
Applicant Signature/Firma Required/Obligatorio		Date/Fecha	
Name of Emergency Contact/Contacto de Emergencia	Relationship/Relación	Emergency Phone/Numero de Emergencia	

Condition/Mobility Aids Checklist
Application for Dial-A-Ride Service

Please check all conditions that apply to you:

- ☐ Amputation
- ☐ Autism
- ☐ Balance Problems
- ☐ Blind or Low Vision
- ☐ Brain Injury
- ☐ Breathing Condition
- ☐ Cognitive Disability
- ☐ Confusion
- ☐ Deaf or Hard of Hearing
- ☐ Dialysis Required
- ☐ Frail
- ☐ Memory Loss
- ☐ Non-Verbal
- ☐ Obesity
- ☐ Pain
- ☐ Panic
- ☐ Paralysis
- ☐ Psychosis
- ☐ Seizures
- ☐ Significant Limitation of Activity

When you travel outside your home, what mobility aids do you use? Check all that apply:

- ☐ None
- ☐ White Cane
- ☐ Dialysis Required
- ☐ Support Quad Cane
- ☐ Walker
- ☐ Portable Oxygen
- ☐ Other (Please specify)_____
- ☐ Powered Wheelchair
- ☐ Manual Wheelchair
- ☐ Significant Limitation of Activity
- ☐ Powered Scooter
- ☐ Personal Care Attendant (PCA)
- ☐ Service Animal

Individual & Mobility Information Application for Dial-A-Ride Service

1. Please state your disability(s):_____

_____

_____

2. What is the nearest street intersection to your home? (Example E 27th @ S Oak)

_____

3. Can you walk or use your wheelchair or assistive device(s) to get from your home to that intersection without assistance? Yes ☐ No ☐

If no, please explain:_____

4. Can you find your way to a bus stop without getting lost? Yes ☐ No ☐

If no, please explain:_____

5. How long can you stand and wait for a bus?

☐ 15 minutes ☐ 10 minutes ☐ 5 minutes ☐ Less than 5 minutes

6. All buses have a 'destination sign' in front which shows the route name and number. Can you read a bus destination sign? Yes ☐ No ☐

Can you ask the driver where the bus is going? Yes ☐ No ☐

Can you give or write a note to the driver? Yes ☐ No ☐

Can you understand the driver's answer? Yes ☐ No ☐

If no to any questions, please explain:_____

_____

7. In your opinion, do you feel that your disability is conditional or circumstantial?

Yes ☐ No ☐ If yes, please explain:_____

_____

8. If you were on a bus, could you pay the fare by putting money in the fare box?

Yes ☐ No ☐ If no, please explain:_____

_____

9. If you were on the bus, could you recognize where you needed to get off of the bus? Yes ☐ No ☐

If no, please explain:_____

10. Please tell us about the time when you ***can*** use BFTs local bus service. (Example: If short distance to bus stop; take attendant; need to get somewhere the same day, etc.)_____

_____

11. Have you ever received Orientation and Mobility Training (Travel Training)? Yes ☐ No ☐

If yes, please list which BFT routes you learned to travel:_____

_____

12. Please tell us why you feel that you ***cannot*** use BFTs local bus service for some or all trips. (Example: surgery, injury, weather, fatigue (conditional).)_____

_____

12a. If you face challenges that prevent you from using fixed routes, please tell us what kinds (Example: No sidewalks in my area; no accessible bus stops).

_____

13. How do you currently travel (Example: self, family, friends, bus, Dial-A-Ride, etc.)?_____

14. Do you require someone to travel with you? Yes ☐ No ☐

If yes, please explain:_____

_____

15. Can you wait independently or alone at your residence and places to which you travel? Yes ☐ No ☐

If no, please explain:_____

_____

Transit
BEN FRANKLIN TRANSIT

APPLICANT NAME:_____

Is there anything about your disability/limiting condition that may help us better understand your travel abilities and limitations?

_____

_____

_____

_____

_____

_____

DID YOU KNOW?

Ben Franklin Transit (BFT) offers free training to learn how to ride the local bus! Participation in travel training is not a basis to limit or deny your Dial-A-Ride eligibility. Are you interested?

☐ Yes (A BFT Travel Trainer will contact you soon.)

☐ No (Please explain below.)

_____

_____

_____

AGREEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this application, you authorize the release of information to Ben Franklin Transit or it's representatives to evaluate your eligibility for Dial-A-Ride service. Please be advised that we will use your statements to determine your eligibility for Dial-A-Ride Service.

Ben Franklin Transit may share your eligibility determination with other transportation providers, upon request, to facilitate travel in other transit districts.

This form must be signed by the applicant or, if applicable, by the applicant's Legal Guardian or Power of Attorney. If the applicant is under 18 years of age, a parent or Legal Guardian must sign this form. If a Legal Guardian or Power of Attorney will be signing this form, the following attachments are required.

- ☐ Legal Guardian: Copies of current Letters of Guardianship and the Order Appointing Guardian document from the court.
- ☐ Power of Attorney: Current documentation that grants the Power of Attorney the right to sign a medical release form on behalf of the applicant.

I HEREBY CERTIFY, under penalty of perjury, under the laws of the State of Washington, that the information provided on this form is true and correct.

Signature (required)_____Date:_____

☐ Applicant ☐ Legal Guardian ☐ Power of Attorney

Printed Name_____Phone: (____)_____

If a Legal Guardian or Power of Attorney completed this form, please complete the following (please print):

Printed Name_____Phone: (____)_____

Relationship to Applicant_____

DEAR PHYSICIAN OR HEALTHCARE PROFESSIONAL:

We need your assistance in determining eligibility for services provided by Dial-A-Ride to persons with disabilities who are unable to use local bus transportation. We are seeking information as to what prevents the person from using local bus services that provide transportation throughout the local area. BFT's buses are equipped with ramps and kneeling features to assist with boarding, as well as automatic announcements of major stops to help riders know where they are at along the route. The American with Disabilities Act of 1990, 49 CFR 37.121, Subpart F states- "...each public entity operating a fixed route system shall provide para transit or other special service to individuals with disabilities that is comparable to the level of service provided to individuals without disabilities who use the fixed route system." "By complementary, DOT means service for individuals with disabilities who cannot use the fixed route system." The information requested of you in the following sections will be used to help determine the applicant's Dial-A-Ride eligibility. It is important that all the 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.

1. Have you previously seen this patient? Yes ☐ No ☐

2. Please rate (Excellent/Good/Fair/Poor/None/Don't Know) the applicant in terms of:

	Excellent	Good	Fair	Poor	None	Don't Know
A. Upper Body Strength						
B. Lower Body Strength						
C. Coordination						
D. Balance						
E. Self-Awareness						
F. Independent Judgment						
G. Sense of Direction						
H. Ability to Understand and Follow Instructions						
I. Verbal Communication						
J. Written Communication						
K. Stamina and Endurance						

Applicant Name: _____

A licensed Medical or Mental Health provider, who is familiar with the applicant listed above, must complete this form.

Ben Franklin Transit (BFT) will use the information you provide to help determine the applicant's Dial-A-Ride (paratransit) eligibility in accordance with the Americans with Disabilities Act. Age, convenience of the service, fear of falling, inability to drive, and inability to carry packages are not qualifying factors for eligibility. If you have any questions, please contact BFT's Dial-A-Ride team at **509.735.0160**.

Please review the information provided by the applicant. Based on your knowledge of the applicant's condition, is the information accurate?

☐ Yes ☐ No ☐ Somewhat

If you checked "No" or "Somewhat," please explain: _____

_____

_____

_____

_____

DIAGNOSIS/DISABILITY (not symptoms)	**DEGREE OF IMPAIRMENT** (circle one)			**DATE OF ONSET** (if known)
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____

Is the applicant's need for Dial-A-Ride service temporary or permanent?

☐ Temporary, until _____ ☐ Permanent

PHYSICIAN OR HEALTHCARE PROFESSIONAL'S CERTIFICATION

I certify that the information that I have provided herein is a fair representation of this applicant's medical impairment or condition and is accurate to the best of my knowledge. I understand that the information provided herein will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that Dial-A-Ride may contact me for clarification of any information that I have provided, and that I will reply in good faith.

Physician/Health Professional's Full Name:

_____

Institution/Facility/Agency Name:_____
Street Address:

Suite #:_____City:_____State:_____
Zip Code: _____ Phone: Fax: _____
Credentials: _____ Specialty:

Physician/Health Professional Signature:_____
Date:

NOTE: Additional signature of physician/health professional on his/her letterhead or prescription verifying completion of this application is required.