Dial-A-Ride Application Process

1. Completely fill out the <u>Tar River Transit Certification Application for ADA</u>

<u>Paratransit Eligibility</u> and return it to Tar River Transit. **Keep this page for your**<u>own information.</u>

Tar River Transit P.O. Drawer 1180 Rocky Mount, NC 27802

- 2. The assessor will call you to schedule a home visit to ask you some questions, and to assess whether or not you are eligible for DARTS. The assessor will then send the application back to Tar River Transit.
- 3. The Transit Administrator will then take your application and the information gathered in the visit by the assessor and make a determination.
- 4. Once a determination has been made, Tar River Transit will mail you a letter informing you whether or not your application has been approved. If your application was approved you will receive the following:
 - a) a copy of the Dial-A-Ride Guidelines
 - b) a copy of the Dial-A-Ride No Show Policy
 - c) your personalized Dial-A-Ride ID Card

If you live outside of the Dial-A-Ride service area, you may still use the service for trips that start or end in the service area; however, it is your responsibility to arrive within the service area.

If your application is denied, a letter will be sent stating the reason. You may be offered the opportunity to apply for a Tar River Transit handicapped half-fare card. Appeals of the Transit Administrator's determination should be submitted in writing to the Director of Engineering.

5. The Transit Administrator has twenty-one (21) days from receipt of your application to make a final determination. Please be patient as this process may take some time.

TAR RIVER TRANSIT CERTIFICATION APPLICATION FOR ADA PARATRANSIT ELIGIBILITY

The information obtained in this certification process will only be used by Tar River Transit for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

	NAME:		*******	*******		
2.	ADDRESS:					
	CITY:	STATE:	ZIP CODE:			
3.	TELEPHONE #: (HOME)		(WORK)			
4.	DATE OF BIRTH:/	/				

	Is this condition temporary?	If Yes, exp	ected duration until			
6.	How does this disability prevent you from using fixed route service? Please explain completely. Use an additional sheet if needed.					
7.	Are there any other effects of your disa	bility of which	we need to be aware?			

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY TAR RIVER TRANSIT.

8. Do you us	e any of the following aids to mobility? (Check all that apply)	
Manual or pov	vered wheelchair Walker Powered scooter	
Cane Cru	tches Personal care attendant Guide Dog	
9. Do you red	quire a Personal Care Attendant when you travel using transit?YesNeg	0
10. Please ans	swer the following questions:	
Can you trave	I 200 feet without the assistance of another person?	
Yes No	o Sometimes	
Can you trave	I ¼ mile without the assistance of another person?	
Yes No	o Sometimes	
Can you trave	I ¾ mile without the assistance of another person?	
Yes No	o Sometimes	
Can you climb	three 12-inch steps without assistance except a railing?	
Yes No	o Sometimes	
11. In case of	an emergency contact:	
NAME:		
TELEPHONE	NUMBER:	
TTY/TDD NUI	MBER:	
12. I hereby ce	ertify that the above information given is correct.	
SIGNATU	RE:	
DATE:	/	
If this applicatio complete the fo	n has been completed by someone other than the person requesting certification, that person llowing: Name:	n must
	Address:	
	City: State: Zip:	
	Daytime phone:	
	Signadi Data / /	

TO THE APPLICANT:

In order for Tar River Transit to evaluate your request, it may be necessary to contact a physician or other professional to confirm or elaborate on the information you have provided. Please complete the following information and authorization.

THE FOLLOWING PHYSICIAN , HEALTH REHABILITATION PROFESSIONAL (C AND IS AUTHORIZED TO PROVIDE INFORM COMPLETE ITS EVALUATION OF MY APPLIC	CHECK ONE) IS FAMIL IATION NECESSARY F	IAR WITH MY DISABILITY
Physician/Professional's Name		
Address		
City	State	Zip
Phone Number		
Applicant's Name (Print or type)		
Applicant's Date of Birth//		
Applicant's Signature		Date