

Dial-A-Ride Application Process

1. Completely fill out the Tar River Transit Certification Application for ADA Paratransit Eligibility and return it to Tar River Transit. **Keep this page for your own information.**

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.

1. NAME: _____

2. ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

3. TELEPHONE #: (HOME) _____ (WORK) _____

4. DATE OF BIRTH: ____/____/____

5. **What** is the disability which prevents you from using our fixed route service?

Is this condition temporary? _____ If Yes, expected 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 disability 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 use any of the following aids to mobility? (Check all that apply)

Manual or powered wheelchair___ Walker___ Powered scooter___

Cane___ Crutches___ Personal care attendant___ Guide Dog___

9. Do you require a Personal Care Attendant when you travel using transit? ___Yes ___No

10. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?

Yes___ No___ Sometimes_____

Can you travel ¼ mile without the assistance of another person?

Yes___ No___ Sometimes_____

Can you travel ¾ mile without the assistance of another person?

Yes___ No___ Sometimes_____

Can you climb three 12-inch steps without assistance except a railing?

Yes___ No___ Sometimes_____

11. In case of an emergency contact:

NAME:_____

TELEPHONE NUMBER:_____

TTY/TDD NUMBER:_____

12. I hereby certify that the above information given is correct.

SIGNATURE:_____

DATE: ___/___/___

If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____

Signed: _____ Date ___/___/___

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 CARE PROFESSIONAL** _____ OR **REHABILITATION PROFESSIONAL** _____ (**CHECK ONE**) IS FAMILIAR WITH MY DISABILITY AND IS AUTHORIZED TO PROVIDE INFORMATION NECESSARY FOR TAR RIVER TRANSIT TO COMPLETE ITS EVALUATION OF MY APPLICATION.”

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 _____