



BEN FRANKLIN TRANSIT
DIAL-A-RIDE

DIAL-A-RIDE PARATRANSIT APPLICATION



Ben Franklin Transit (BFT) has proudly offered Dial-A-Ride (DAR) paratransit service throughout the Tri-Cities community for over 40 years. Dial-A-Ride drivers provide door-to-door transportation to clientele with disabilities that prevent them from utilizing the regular fixed-route bus system. Dial-A-Ride meets ADA complementary paratransit service requirements.

To see if you or a loved one qualifies, please complete and submit this application to BFT Dial-A-Ride staff, who will evaluate it using criteria established by the Americans with Disabilities Act (ADA) within 21 calendar days of receipt. Once your application has been evaluated, you will receive a decision letter via U.S. mail. If an application is not processed within 21 days, presumptive eligibility is granted on the 22nd day until and unless the application is denied in writing. If your application is denied, the letter will contain information about how to appeal the decision. Eligible riders may be accompanied by a companion or personal care assistant (PCA).

Ben Franklin Transit | 509.735.0160 | www.bft.org

DIAL-A-RIDE

APPLICATION CHECKLIST



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To be considered for BFT Dial-A-Ride paratransit service, you must complete this application in its entirety. **Incomplete applications will be returned.**

Additionally, an in-person functional assessment may be required. If you have any questions or need assistance completing this application, **please call 509.735.0160.**

CHECKLIST & INSTRUCTIONS

- Complete pages 1-6. Answer all questions and thoroughly explain how your disabilities prevent you from using the regular bus system.
- Ensure the application form is signed on **page 6** and names are printed clearly. If you are under the age of 18, your parent or legal guardian is required to sign the application. If your Legal Guardian or Power of Attorney (POA) is signing the application, please attach current Legal Guardian/POA documentation.
- Please ensure that a licensed healthcare provider/physician has reviewed the entire application and completed the Verification Form (**pages 7-8**), which must be returned with 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:

- | | |
|---|--|
| <ul style="list-style-type: none">• Via fax to 509.734.5195• U.S. mail to:<ul style="list-style-type: none">⇒ 7109 W. Okanogan PlaceKennewick, WA 99336 | <ul style="list-style-type: none">• In person to:<ul style="list-style-type: none">⇒ 7109 W. Okanogan PlaceKennewick, WA 99336 or⇒ 1000 Columbia Park TrailRichland, WA 99352 |
|---|--|

Applications are considered complete when all questions have been answered and all signatures and contact information of professional sources have been provided, including Legal Guardian/POA documents, if applicable.

APPLICATION FOR DIAL-A-RIDE SERVICE



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INSTRUCTIONS

On pages 1-6 of this application, BFT asks for information about you, your mobility, and your ability to use fixed-route bus service. Please answer ALL questions carefully and completely. A friend, guardian, agency service representative, or family member may help you. We cannot determine your eligibility for Dial-A-Ride service without this information.

Pages 7-8 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? Yes No

If yes, Client ID# _____

Name of Applicant/Last		First	Middle	Male <input type="checkbox"/>	Female <input type="checkbox"/>
				Non-binary <input type="checkbox"/>	Prefer not to answer <input type="checkbox"/>
Address		Apartment #	City	Zip Code	
Date of Birth (Optional) / /		Home Phone Number		Other Phone Number	
Apartment Complex Name				Gate Code	
Mailing Address (If different than home address)		Apartment #	City	Zip Code	
Email					
Preferred Language			Are you a U.S. Veteran? (Optional) Yes <input type="checkbox"/> No <input type="checkbox"/>		Arc Participant? Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Emergency Contact		Relationship		Emergency Phone	

Application for Dial-A-Ride Service CONDITIONS/MOBILITY AIDS



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PLEASE CHECK ALL CONDITIONS THAT APPLY TO YOU:

- | | |
|---|---|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Frail |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Nonverbal |
| <input type="checkbox"/> Blind or Low Vision | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Breathing Condition | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Cognitive Disability | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Deaf or Hearing Impairment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dialysis Required | <input type="checkbox"/> Significant Limitation of Activity |

WHEN YOU TRAVEL OUTSIDE YOUR HOME, WHICH MOBILITY AIDS DO YOU NEED? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Support Quad Cane | <input type="checkbox"/> Powered Scooter |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Personal Care Attendant (PCA) |
| <input type="checkbox"/> Portable Oxygen | <input type="checkbox"/> Other (Please specify below) |

Application for Dial-A-Ride Service

INDIVIDUAL & MOBILITY INFORMATION



1. Please state your disability(ies): _____

2. What is the street intersection nearest your home? (*Example: East 27th @ South Oak*)

3. Can you walk or use your wheelchair or other 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. Do you currently ride the regular fixed-route buses?
 Yes No
Please explain: _____

7. 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: _____

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: _____

Application for Dial-A-Ride Service INDIVIDUAL & MOBILITY INFORMATION



9. If you were on the regular bus, could you recognize where you needed to get off?

Yes No

If no, please explain: _____

10. Please tell us about the situations when you **can** use BFT's regular fixed-route bus service. (Examples: If it is a short distance to the bus stop; with an attendant; when I need to get somewhere the same day) _____

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. a. Please tell us why you **cannot** use BFT's regular fixed route bus service for some or all trips. (Examples: Surgery, injury, weather, fatigue--conditional)

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

13. How do you currently travel? (Examples: Self, family, friends, bus, Dial-A-Ride)

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: _____

Application for Dial-A-Ride Service AGREEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION



By signing this application, you authorize the release of information to Ben Franklin Transit or its representatives to evaluate your eligibility for Dial-A-Ride service using the information you provided in this application.

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 (include attachment)

Power of Attorney (include attachment)

Name (applicant) _____ Phone (_____) _____

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

Name _____ Phone (_____) _____

Relationship to Applicant _____

Application for Dial-A-Ride Service LICENSED HEALTHCARE PROVIDER/ PHYSICIAN VERIFICATION FORM



Applicant Name: _____

Please ensure that a licensed healthcare provider/physician who is familiar with the applicant has reviewed the entire application prior to completing this form.

We need your assistance in determining eligibility for Dial-A-Ride services for the applicant named above. We are seeking information regarding the limitations this applicant faces in using bus service for local transportation. BFT's buses are equipped with ramps, lifts, and kneeling features to assist with boarding, as well as automatic announcements of major stops to help riders know where they are along the route.

The information you provide in the following sections will be used to help determine the applicant's Dial-A-Ride eligibility. It is important that all questions are 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 contact you for clarification. Thank you for your cooperation.

Have you previously seen this patient? Yes No

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
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____

Is the applicant receiving treatment for the above disabilities? _____

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

Permanent Temporary - How Long: _____

Application for Dial-A-Ride Service LICENSED HEALTHCARE PROVIDER/ PHYSICIAN VERIFICATION FORM



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Please rate the applicant's abilities while using their mobility aid 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						

If visually impaired, what is the applicant's best corrected acuity?

Date of Testing: _____ (Snellen?) (R) _____ (L) _____

Field Restriction: (R) _____ (L) _____

PHYSICIAN OR HEALTHCARE PROFESSIONAL'S CERTIFICATION

I certify that the information 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 will be used for the sole purpose of determining the applicant's eligibility for paratransit services. I also agree that Dial-A-Ride staff may contact me for clarification of any information I have provided, and that I will reply in good faith.

Healthcare Professional's Full Name: _____

Institution/Facility/Agency Name: _____

Area of Specialty: _____

Street Address: _____ Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Healthcare Professional's Signature: _____ Date _____