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).

DIAL-A-RIDE
APPLICATION CHECKLIST

BEN FRANKLIN TRANSIT
DIAL·A·RIDE

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 509.734.5516.**

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:

- **Via fax to 509.734.5195**
- **U.S. mail to:**
  - ⇨ **7109 W. Okanogan Place Kennewick, WA 99336**
- **In person to:**
  - ⇨ **7109 W. Okanogan Place Kennewick, WA 99336 or**

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

BEN FRANKLIN TRANSIT DIAL·A·RIDE

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 Eligibility at 509.734.5516.

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

If yes, Client ID#_____

Name of Applicant/Last	First	Middle	Male ❑ Female ❑ Non-binary ❑ Prefer not to answer ❑
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? Yes ❑ No ❑		Arc Participant? Yes ❑ No ❑
Name of Emergency Contact	Relationship	Emergency Phone	

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

BEN FRANKLIN TRANSIT
DIAL·A·RIDE

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 Hearing Impairment
- ❑ Dialysis Required
- ❑ Frail
- ❑ Memory Loss
- ❑ Nonverbal
- ❑ Obesity
- ❑ Pain
- ❑ Panic
- ❑ Paralysis
- ❑ Psychosis
- ❑ Seizures
- ❑ Significant Limitation of Activity

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

- ❑ None
- ❑ White Cane
- ❑ Service Animal
- ❑ Support Quad Cane
- ❑ Walker
- ❑ Portable Oxygen
- ❑ Powered Wheelchair
- ❑ Manual Wheelchair
- ❑ Cane
- ❑ Powered Scooter
- ❑ Personal Care Attendant (PCA)
- ❑ Other (Please specify below)

_____

_____

_____

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

BEN FRANKLIN TRANSIT
DIAL·A·RIDE

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

BEN FRANKLIN TRANSIT
DIAL·A·RIDE

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
INDIVIDUAL & MOBILITY INFORMATION

BEN FRANKLIN TRANSIT
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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 offers free training to learn how to ride the local bus routes. Participation in travel training will not affect your Dial-A-Ride eligibility. Are you interested?

- ❑ Yes (A BFT employee will contact you soon.)
- ❑ No

If no, please explain: _____

_____

_____

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

BEN FRANKLIN TRANSIT
DIAL·A·RIDE

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

BEN FRANKLIN TRANSIT
DIAL·A·RIDE

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

BEN FRANKLIN TRANSIT
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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 _____