



**SunLine Transit Agency
ADA Paratransit Eligibility
Certification Application**

This certification form will be used to determine your eligibility for SunDial Paratransit Services. SunDial is a curb-to-curb public transportation service for individuals with disabilities who are prevented from using SunBus fixed-route transportation. SunBus and SunDial services are fully accessible to individuals with disabilities.

You must complete the entire form and answer every question. Incomplete forms will not be considered. A physician must verify your disability, prognosis and date of occurrence. Verification can be obtained directly from your physician or from an agency that has record of the physician statement on file. This information must be submitted with the application and written on the physicians' official letterhead or on the Physician Verification of Disability Form. The information you provide is confidential. It will only be shared with agencies involved with SunLine's eligibility determination process and other transit providers to facilitate travel in those areas, and will not be provided to any other person or agency, except as provided by the California Open Records Act.

PART 1: Applicant Information
Please print or type clearly

OFFICE USE ONLY	
<input type="checkbox"/> / Conditional	<input type="checkbox"/> / Unconditional
<input type="checkbox"/> / In Service Area	<input type="checkbox"/> / Out Service Area
<input type="checkbox"/> / Previous Client	<input type="checkbox"/> / New Client
ADA # _____	Exp. Date _____

Last Name	First Name	Middle Initial
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Street Address	Building/Apt No.	Apartment Name
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City	State	Zip Code
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Home Phone	Work Phone
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If this is a "Gated Community", please provide gate code _____

Mailing address, if different from above:

Address	City	State	Zip Code
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Date of Birth	<input type="checkbox"/> / Male	<input type="checkbox"/> / Female
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If you have a Paratransit I.D. Card, please provide I.D. number _____

IN CASE OF EMERGENCY NOTIFY

Name	Relationship	Home Phone/Work Phone
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Address	City	State	Zip Code
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PART 2: Information on disability and mobility equipment

1. Check all that apply to the nature of your disability or condition:

- | | |
|--|---|
| <input type="checkbox"/> / Cardiovascular Impairment | <input type="checkbox"/> / Muscular-Skeletal Disability |
| <input type="checkbox"/> / Developmental Disability | <input type="checkbox"/> / Neurological Disability |
| <input type="checkbox"/> / Difficulty Walking / Hearing | <input type="checkbox"/> / Respiratory Impairment |
| <input type="checkbox"/> / Disability Wheelchair User | <input type="checkbox"/> / Seizure Disorder |
| <input type="checkbox"/> / Mental / Cognitive Disability | <input type="checkbox"/> / Visual Disability |

2. How does your disability prevent you from using SunBus?

3. Is your disability permanent?

- / Yes
/ No If No, what is the expected duration of your disability? ____/____/____/

4. Have you ever had a seizure?

- / Yes If Yes, what type? _____ How often? _____
/ No

5. Are seizures controlled with medication?

- / Yes
/ No

6. Do you use any of the following mobility aids? (Check all that apply)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> / Manual Wheelchair | <input type="checkbox"/> / Walker | <input type="checkbox"/> / White Cane |
| <input type="checkbox"/> / Powered Wheelchair | <input type="checkbox"/> / Braces | <input type="checkbox"/> / Prosthesis |
| <input type="checkbox"/> / Powered Scooter | <input type="checkbox"/> / Service Animal | <input type="checkbox"/> / Crutches |
| <input type="checkbox"/> / Portable Oxygen | <input type="checkbox"/> / Cane | |
| <input type="checkbox"/> / Other _____ | | |

7. Do you require an aide/attendant to use paratransit service?

(If Yes, the aide/attendant must always accompany you when using the service.)

- / Yes
/ No

PART 3: Your current travel

List your 3-4 most frequent destinations and how you get there now?

Destination Address	Frequency of Travel	How you get there now
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PART 4: Verification of Information

I verify that all statements are true and correct to the best of my knowledge. I understand that supplying false information can disqualify my application and/or subsequent registration. I authorize SunLine to obtain verification of any information given in this application and to obtain essential medical information necessary for determination of paratransit eligibility. I also agree to submit myself for an in-person evaluation by SunLine and/or its acting agency for determination of paratransit eligibility.

Applicant's Signature	Date
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If complete by someone other than applicant:

Name	Relationship	Phone No.
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Signature	Date
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Once you have completed this form, please mail to: SunLine Transit Agency
32-505 Harry Oliver Trail
Thousand Palms, CA 92276

Or fax to: 760-343-2634



SunLine Transit Agency
 Paratransit Services
Under the Americans With Disabilities Act of 1990 (ADA)

Physician Verification of Disability Form
 (Deliver or mail to your doctor)

Doctor: Please complete, sign and mail this Verification of Disability form as soon as possible. Your patient is being considered for enrollment in SunDial, a paratransit service. The information provided in this form is intended to verify any conditions/diseases that prevent your patient from using SunBus fixed-route services.

Mail to: 32-505 Harry Oliver Trail, Thousand Palms, CA 92276, ATTN: Customer Service
 Or fax to: 760-343-2634

Patient Name _____

DOB _____ Date _____

The patient named above ___/ is currently being treated or ___/ was formerly treated by me.

Name of condition/ disease: _____ Date of onset: _____

Prognosis: _____

Please explain how this prevents your patient from using regular bus service on a fully accessible vehicle. (i.e. wheelchair lift equipped):

Does this patient require a travel aide or attendant? ___/ Yes ___/ No

Disability Status (select one):

___/ Patient will be temporarily disabled of ___ months.

___/ Patient is considered permanently disabled.

FOR VISUAL IMPAIRMENT

Visual Fields or Visual Acuity with best correction (must complete for both eyes):

Right eye: _____ Left eye: _____

My signature below certifies that the above information is accurate.

 ** Physician Signature and Credentials (M.D., O.D.)

 Print Physician Name and Credentials (M.D., O.D.)

 License Number

 State

 Physician's Office Phone Number

** Must be signed by licensed physician.

***** IMPORTANT NOTICE *****
THIS FORM WILL NOT BE
ACCEPTED UNLESS COMPLETED
IN ITS ENTIRETY BY THE
SIGNING PHYSICIAN.