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	
__/ Conditional	__/ Unconditional
__/ In Service Area	__/ Out Service Area
__/ Previous Client	__/ New Client
ADA # _____	Exp. Date _____

_____

Last Name | First Name | Middle Initial

_____

Street Address | Building/Apt No. | Apartment Name

_____

City | State | Zip Code

_____

Home Phone | Work Phone

If this is a "Gated Community", please provide gate code _____

Mailing address, if different from above:

_____

Address | City | State | Zip Code

_____ __/ Male __/ Female

Date of Birth

If you have a Paratransit I.D. Card, please provide I.D. number _____

IN CASE OF EMERGENCY, NOTIFY

_____

Name | Relationship | Home Phone/Work Phone

_____

Address | City | State | Zip Code

PART 2: Information on Disability and Personal Mobility Equipment

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

__/ Cardiovascular Impairment
__/ Developmental Disability
__/ Difficulty Walking / Hearing
__/ Disability Wheelchair User
__/ Mental / Cognitive Disability
__/ Muscular-Skeletal Disability
__/ Neurological Disability
__/ Respiratory Impairment
__/ Seizure Disorder
__/ 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)

__/ Manual Wheelchair
__/ Powered Wheelchair
__/ Powered Scooter
__/ Portable Oxygen
__/ Walker
__/ Braces
__/ Service Animal
__/ Cane
__/ White Cane
__/ Prosthesis
__/ Crutches
__/ 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 Destinations

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

Destination Address Frequency of Travel How You Get There, Now

_____

_____

_____

_____

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

If complete by someone other than applicant:

_____

Name Relationship Phone No.

_____

Signature Date

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.) Physician Printed 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.