



Dial-A-Ride

Checklist & Eligibility Application

Thank you for your interest in Ben Franklin Transit's Dial-A-Ride paratransit service.

If you are seeking eligibility for service, you must complete the entire application process required by the Americans with Disabilities Act, including:

1. The Application form (extra documentation is required if someone other than applicant signs the form, listed on next page)
2. The enclosed Licensed Provider Verification form
3. An In-person Assessment, if required.

Please be sure to print this document double sided. If you have questions or need assistance completing the application form, please call 509.735.0160.

CHECKLIST & INSTRUCTIONS

All 8 pages of the completed application must be returned at the same time. Before submitting the application form, please:

- Read the Dial-A-Ride brochure included with the application form.
- Complete pages 1-5 of the application.
- Ensure the application form is signed on page 5. Please print clearly.
 - If you are under 18, your parent or Legal Guardian* is required to sign the application
 - If you have a Power of Attorney*, he or she must sign the application.
- Ensure the **Licensed Provider Verification Form** (page 7-8) has been completed by a medical provider and is included in the application.
 - The 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 Assistant or ARNP | Certified
Orientation & Mobility Specialist

*** If Legal Guardian or Power of Attorney will be signing on your behalf, please provide the following:**

- 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.

Notification

After review of your completed application form, Ben Franklin Transit will notify you if additional information and/or an in-person assessment is required. We will make eligibility determinations within 21 calendar days of receiving **all** required information and we will notify you by mail.

Once completed, send all pages of the completed application to us:

Fax: **509.734.5195**

or

Mail: **Ben Franklin Transit
Attn: Dial-A-Ride
1000 Columbia Park Trail
Richland, WA 99352**

Basic Dial-A-Ride Information

Hours of Operation:

Monday-Friday:	6 a.m. to 10 p.m.
Saturday:	7 a.m. to 10 p.m.
Sunday:	No service

Reservations:

509-735-0160 (or toll-free 877-646-4287)

Reservation Hours:

Monday-Friday:	8 a.m. to 5 p.m. (scheduling one day in advance)
Saturday-Sunday:	8 a.m. to 5 p.m. (scheduling rides for Monday only)

More Information:

Online at: **bft.org/Services/Dial-A-Ride**

DIAL-A-RIDE ELIGIBILITY APPLICATION

Type of Application (Official use only)

New Recertification ID #: _____ Exp: _____

Ben Franklin Transit assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. For more information, visit bft.org/Civil-Rights.

All phone numbers are accessible for people who are deaf or hard of hearing through Relay 711. To request alternative formats of this document, please call **509.735.0160**.

Contact Information

Last Name _____ First Name _____ M.I. _____

Mailing Address _____ Apt./Sp. # _____

City _____ State _____ Zip _____

Address where Dial-A-Ride will pick you up
(if different from mailing address):

Street Address _____ Apt./Sp. # _____

City _____ State _____ Zip _____

Date of Birth _____ Male Female
MM/DD/YYYY

Home Phone (_____) _____ Cell Phone (_____) _____

Email Address _____

Emergency Contact

Name _____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____) _____

If we are unable to contact you, please list an alternate contact:

Alternate Contact

Name _____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____) _____

Applicant Name: _____

By providing emergency/alternate numbers, you authorize BFT or its representatives to contact the individuals listed regarding your paratransit service.

About You

1. Do you speak and understand English? Yes No (list language) _____

2. What is your disability or limiting condition? (use page 6 if needed)

3. Do your limitations change from time to time because of medical treatments, medications, or for other reasons?

No Yes (please explain, use page 6 if needed):

4. Is your need for Dial-A-Ride service long term or temporary?

Long term Temporary - How long? _____

5. Is your memory affected due to your disability/limiting condition?

No Yes If yes: Short-term Long-term

Applicant Name: _____

6. Do you currently ride the standard bus? Yes No

7. Have you ever ridden the standard bus without someone's assistance?
 No Yes If yes, how long ago? _____

8. Are you able to independently:	Yes	No	Sometimes
a. Travel to and from a bus stop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Get on and off a ramp-equipped bus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Ask for, understand, and/or follow directions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Plan, understand, and follow through with the actions necessary to take a bus trip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked "No" or "Sometimes" on question 8, please explain.

9. Which of the following mobility aids or equipment do you use when you leave your home? Check all that apply and indicate the percentage of time you use the aid. (Example: support cane 90%, no aids 10%).

- | | |
|---|---|
| <input type="checkbox"/> No aids ____% | <input type="checkbox"/> White cane ____% |
| <input type="checkbox"/> Motorized wheelchair ____% | <input type="checkbox"/> Motorized scooter ____% |
| <input type="checkbox"/> Support cane ____% | <input type="checkbox"/> Manual wheelchair ____% |
| <input type="checkbox"/> Crutches ____% | <input type="checkbox"/> Other (please specify) ____% |
| <input type="checkbox"/> Walker ____% | _____ |

If you checked more than one aid, please describe the circumstances when you use each one.

If you use a motorized wheelchair or motorized scooter, skip to question 10.

Applicant Name: _____

10. When you walk outside your home, how far can you walk by yourself or with the use of a mobility aid such as a cane or walker?

Number of blocks _____ Less than 1 block Not at all

11. If you use a manual wheelchair, how far are you able to self-propel?

Number of blocks _____ Less than 1 block Not at all

12. If you use a motorized wheelchair or scooter, how far are you able to travel without someone's help?

Number of blocks _____ Less than 1 block Not at all

13. If you qualify for Dial-A-Ride service, will you need to:
Use the lift to board the bus?

Yes No Sometimes

Bring a helper (Personal Care Attendant) with you?

Yes No Sometimes

14. Is there anything else about your disability/limiting condition that might help us better understand your travel abilities and limitations?
(use page 6 if needed)

DID YOU KNOW?

Ben Franklin Transit (BFT) offers free training to learn how to ride the standard bus! Participation in travel training is not a basis to limit or deny your Dial-A-Ride eligibility. Are you interested?

Yes (A BFT Travel Trainer will contact you soon.)

No (Please explain below)

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. Please be advised that we will use your statements to determine your eligibility for Dial-A-Ride service.

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 application, 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 the penalty of perjury, under the laws of the State of Washington, that the information provided on this application is true and correct.

Signature (required) _____ Date _____

Applicant Legal Guardian Power of Attorney

Printed Name _____ Phone (____) _____

If a legal guardian or power of attorney signed this application, please complete the following (please print).

Name _____ Phone (____) _____

Relationship to Applicant _____

Question 2 continued: _____

Question 3 continued: _____

Question 14 continued: _____

Applicant Name: _____

LICENSED PROVIDER VERIFICATION FORM

A licensed Medical or Mental Health provider, who is familiar with the applicant listed above, must complete this form.

Ben Franklin Transit (BFT) will use the information you provide to help determine the applicant’s Dial-A-Ride (paratransit) eligibility in accordance with the Americans with Disabilities Act. BFT’s Dial-A-Ride is a tax-supported service for individuals who, because of the effects of their disabilities or limiting conditions, are not able to ride the ramp-equipped and accessible BFT standard bus. Age, convenience of the service, fear of falling, inability to drive, and inability to carry packages are not qualifying factors for eligibility. If you have any questions, please contact BFT’s Dial-A-Ride team at **509.735.0160**.

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 (if known)
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____
_____	Mild	Moderate	Severe	_____

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

- Temporary, until _____ Permanent

Applicant Name: _____

If the applicant has a condition that is expected to improve (i.e. knee replacement or recent stroke), when do you expect the condition to stabilize?

Are any of these conditions episodic or variable in their severity?

No Yes (provide details below)

Provide any additional information that you deem relevant as to why the effects of the applicant's disability/limiting condition will prevent the applicant from using the standard bus service.

I HEREBY CERTIFY under penalty of perjury, under the laws of the State of Washington, that the information on the Licensed Provider Verification form portion of this application is true and correct.

Provider's Signature _____ Date _____

Credentials _____ Specialty _____

Printed Name _____ Organization _____

Phone (____) _____ Address _____

City _____ State _____ Zip _____