

SETD Special Services Application

Please fill out the following application so that we can determine if you are eligible for the following Special Services offered by SETD:

- Priority Seating on Dial-A-Ride
- Dial-A-Ride Service to the Nearest Bus Stop
- Bus Service that deviates off route to your home and/or destination

PART 1. PERSONAL INFORMATION

Please Print Clearly

Name _____
Last Name First Name Middle Initial

Address _____
Street Address & Apartment Number (if any) Complex/Building Name (if any)

City _____ State _____ Zip Code _____

Social Security Number (Optional) _____ Date of Birth _____

Home Phone _____ Work Phone _____

PART 2. MOBILITY EQUIPMENT AIDS OR ASSISTANCE

1. **Will you use a wheelchair or scooter when riding?** Yes No Sometimes
 - a. If yes or sometimes, which device will you use?
 Manual Wheel Chair Motorized Wheelchair Scooter
 - b. If yes or sometimes, can you transfer to a seat in a vehicle? Yes No
2. **Will you use any of these aids when riding? (check all that apply)**
 Cane, White Cane, Walker or Crutches Portable Oxygen
 Communication Aid Service Animal Other _____
3. **Will you be accompanied by a Personal Care Attendant (PCA) when riding?**
(A person who may provide assistance during the ride or at the destination.)
 Yes No Sometimes

PART 3. APPLICANT'S ABILITIES AND NEEDS

4. What is your disability or health condition? (Please explain fully)

5. Is your need for special services.

- Permanent? (Life-long)
 - Temporary? (Provide your best estimate in months _____)
 - Other ? (Please explain)
-

6. Do you currently use SETD bus service?

- No, never use
- No, used to ride, but stopped
- Yes, for all trips
- Yes, for some trips, or some of the time

7. Indicate your ability to do each of the following on your own:

- a. Can you get on or off a bus by using the steps?
 - No I use a wheelchair or scooter. (If you marked this box – skip to question c.)
 - No Yes Sometimes Don't Know
- b. Can you maintain your balance while standing?
 - No Yes Sometimes Don't Know
- c. Can you get to or from the bus stop nearest to your home?
 - No Yes Sometimes Don't Know
- d. Can you wait up to 15 minutes at a bus stop?
 - No Yes Sometimes Don't Know
- e. Can you communicate with a bus driver yourself or with the help of an aid?
 - No Yes Sometimes Don't Know
- f. Are there other conditions which limit your ability to use the bus?
 - I get confused or can't remember where I am going
 - The ground is too uneven or steep
 - I am incontinent or need a restroom frequently
 - Other: Please Describe

8. How far can you walk or travel (with your wheelchair or scooter) by yourself?

- a. I can go _____ city blocks on my best day.
- b. I can go _____ city blocks on my worst day.
- c.

PART 4. CONTACT PERSON

Name of Contact(s) _____

Relationship to Applicant _____

Phone Number (s) _____

Does the applicant require someone to receive them at the destination? No Yes
If yes, the contact person you listed above will be called if no one is available to receive the applicant at the destination.

PART 5. APPLICANTS CERTIFICATION

I certify that the information in this application is true and correct. I understand that providing false information may result in denial of service as well as a penalty under the law. I understand all information will be kept confidential and disclosed only as needed in order to provide services.

I understand that it may be necessary for me to participate in an in-person evaluation to determine my eligibility for SETD's Special Service.

Applicant Signature: _____ (Signature of Applicant or Responsible Party) _____ (Date Signed)

If someone completed this application for you or assisted with this application, please provide the following information:

Name of Person(s) _____

Relationship to Applicant _____

Phone Number(s) _____

SETD **may** contact this person for additional information about the applicant.

PART 6. PROFESSIONAL CONTACT

To the Physician:

2. My Name is (Please print or type): _____

I am a physician licensed under the laws of the State of Oregon or Washington. I have examined the applicant identified herein and it is my opinion that, he/she is within the meaning of the disability definition which follows.

A person must have a permanent impairment due to illness, injury, congenital malfunction or other incapacity or disability that substantially limits one or more of that person’s major life activities. “Permanent impairment” means an impairment which has lasted (or is expected to last) at least 12 months.

3. The following statement describes the medical condition that “substantially limits” one or more major life activities of my patient:

4. _____ (Signature of licensed physician, health or social service professional) _____ (Licensing identification)

_____ (Office Address) _____ (City/State/Zip)

_____ (Telephone Number) _____ (Date)

Important Reminders:

- When this form is returned to SETD, SETD personnel may contact you for clarification purposes
- It is the applicant’s responsibility to complete the application and have it signed by a duly licensed physician. SETD is not liable for any expense. SETD reserves the right to require proof of disability in addition to this Physician’s opinion.

Mail the completed application to Sunset Empire Transportation District, P.O. Box 68, Warrenton, Oregon 97146