

Long Beach Dial-A-Lift Applicant Information Sheet

(For Office Use) Date _____

Received _____ ID# _____ Interview _____

SECTION 1: Personal Information

Full Name: _____

	First		M.I.	Last
DOB			Gender	Phone Number

SECTION 2: Mailing Address if different from home address

P.O. Box or Street Address Apt. #

City State Zip

Authorized to Release Information to:

Name: _____ Relationship: _____

Phone: _____

APPLICATION FORM – Please answer the following questions:

- 1) Under what circumstance(s) are you applying for Dial-A-Lift?
 - Convenience Disabled Referred to Dial-A-Lift, Referred by whom? _____
 - Not able to use the bus for some or all of my transportation needs _____
- 2) What type of disability do you have: Physical Cognitive Visual
- 3) What disability or disabling health condition PREVENTS you from using Public Transportation without the help of another person?
- 4) Explain HOW the disability or disabling health conditions you describe above prevent you from using Public Transportation without the help of another person
- 5) When did you first experience the conditions you described above?
 - Less than 1 year ago 1-5 years ago Longer than 5 years ago
- 6) Is your disability: Permanent Temporary I don't know

7) Do the conditions you described change from day to day in a way that affects your ability to use Public Transportation?

- Yes, could use transportation on some days.
 No, doesn't change Don't know

8) How do you currently travel? (Check all that apply)

- Public Transit Bus Metro Link School Bus Ride Share Programs (Ex. Uber/Lyft)
 Dial-A-Ride Metro Rail Walking
 Ambulette Taxi Service Automobile Other: _____

9) How often do you travel on public transit buses?

- Daily Weekly Monthly Occasionally Never

If you have used a public transit bus or rail in the past, when did you stop? _____ (month/year)

Why did you stop traveling by public transit bus or rail?

10) Do you require assistance when walking to the closest bus stop near your place of residence?

- Yes No

11) Do you require the assistance of a (PCA) Personal Care Attendant (Someone who assists you with daily life functions)?

Yes, I need assistance with:

- Mobility Reading Eating Shopping Medication Communicating
 Other (Specify) _____

I don't have a Personal Care Attendant

12) Indicate which assistive / mobility device(s) you use when travelling or walking outside your home.

- I do not require a support device Respirator / Oxygen Tank Walker
 Scooter Braces Support Cane Crutches Power Wheelchair
 Manual Wheelchair Prosthesis Service Animal
 Other (Specify) _____

13) How far from your home is the nearest public transit bus stop?

- Less than 1 block 1 to 2 blocks 3 to 4 blocks 5 + blocks Unknown

14) On your own or using a support device, are you able to get to and from the public transit bus stop nearest your home? Yes No Sometimes (Describe the circumstances):

15) Do you currently travel with a Personal Care Attendant (PCA), a person such as a home attendant who assists you regularly when you travel outside your home?
 Yes No Sometimes (Describe the circumstance):

16) If you are unable to take some or all of your trips by public transit bus, check off the reasons below. (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> I cannot afford the cost of taking the bus |
| <input type="checkbox"/> I cannot travel to an unfamiliar place | <input type="checkbox"/> I fear travelling by public transit bus |
| <input type="checkbox"/> Distance to public transit bus is too far | <input type="checkbox"/> No curb cuts |
| <input type="checkbox"/> No paved sidewalks | <input type="checkbox"/> Street with Hill |
| <input type="checkbox"/> Extreme Cold | <input type="checkbox"/> Extreme Heat |
| <input type="checkbox"/> It is inconvenient for me to travel by public transit bus | |

17) Please provide your Access Service number:

I certify that my information is true and complete to the best of my knowledge.

Applicant's Signature: _____ Date: _____

*******APPLICANT, PLEASE MAIL THE FOLLOWING:*******

1. Complete application with "Physician's Statement"
2. Access Services eligibility letter or copy of Access card
3. Authorization to Release Information
4. Consent to verify and release eligibility information

TO:

LONG BEACH TRANSIT DIAL-A-LIFT
 1963 E. Anaheim Street
 Long Beach, CA 90813

Long Beach Transit: 562-591-8753
 DAL FAX Number: 562-599-5470

FOR DIAL-A-LIFT USE ONLY

_____ APPROVED

_____ DENIED

REASON FOR DENIAL _____

SIGNED _____ DATE _____