



For Office Use Only

Date entered in DAC system \_\_\_\_\_ Staff \_\_\_\_\_

Date scanned to DAV system \_\_\_\_\_ Staff \_\_\_\_\_

For Office Use Only

Paid: \_\_\_\_\_

Staff Initials \_\_\_\_\_

# Dial-A-Van and Dial-A-Cab

## Application for Disabled Status

(Residents who are younger than 55 years old)



**There is a \$5.00 processing fee per application.**

### Applicant

Please Print or Type

_____		_____		_____		_____	
Last Name	First	Init.	Date of Birth				
_____		_____		_____		_____	
Address Number (No P.O. Boxes)	Street	Apt.	Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/>			
_____		_____		_____		_____	
City	State	Zip Code	Escort: Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Mobility Status:  Ambulatory  Cane  Crutches  Scooter  Walker  Wheelchair  Other \_\_\_\_\_

Disabilities:  Vision Impaired  Hearing Impaired  Other \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Number (\_\_\_\_) \_\_\_\_\_

Emergency Contact Relationship to Cardholder: \_\_\_\_\_

*I hereby certify under penalty that this application is true and correct, to the best of my knowledge, and I agree to release this information for statistical purposes only.*

_____	_____	_____
Applicant or Guardian's Signature	Date	Telephone

### Physician/Agency (to be completed by applicant's physician)

Please Print or Type

**SECTION I** Applicant is eligible for Disabled transportation via Dial-A-Ride because of a transportation dysfunctional impairment causing: (Mark all appropriate categories)

- Requires the use of a wheelchair to travel throughout the community.
- Significant difficulty in boarding or alighting from a standard bus or train.
- Difficulty standing in a moving vehicle.
- Inability to read information signs or symbols.
- Inability to hear announcements by conductors, operators or attendants in public transit vehicles or facilities.
- Inability to qualify for driver's license due to no. \_\_\_\_\_ of Section II.
- Substantial difficulty in effectively utilizing public transportation without special planning or design.

**SECTION II** The dysfunction checked in Section I is due to the following disability: (Mark all appropriate categories)

1.  a. Vision in better eye is 20/100 or less after best correction.  
 b. Visual field is contracted to ten degrees or less from a point of fixation or subtends to an angle no greater than 20.
2.  50% bilateral hearing loss uncorrected by use of a hearing aid.
3.  Musculo-skeletal impairment and instability such as muscular dystrophy, multiple sclerosis, osteogenesis imperfecta, severe arthritis of therapeutic grade III or anatomical state III, or spinal defect class IV or V.
4.  Cardiovascular impairments of function Class III or IV or therapeutic Class C, D, or E.
5.  Respiratory impairment Class 3 or greater.
6.  Amputation of, or anatomical deformity (due to vascular or neurological deficits, traumatic loss of muscle mass or tendons, or x-ray evidence of bony or fibrous ankylosis, joint subluxation) or instability of:  
 both hands       one hand and one foot       one lower extremity at or above tarsal region
7.  Neurological disorder due to brain dysfunction or damage to the central nervous system including cerebral palsy resulting in aberration of motor functions.
8.  Paralysis, incoordination, or functional motor deficit in any two limbs due to brain, spinal, or peripheral nerve injury, including paraplegia, quadriplegia, hemiplegia, etc.
9.  Mental/emotional disability which has required hospitalization and/or the use of potent medications which substantially limits the applicant's ability to effectively utilize public transit systems.
10.  Mental retardation resulting in impairment in adaptive behavior; with an IQ two standard deviations or more below the norm, or 72.
11.  Epilepsy (convulsion disorder) involving impairment of consciousness which occur more frequently than once a month despite prescribed treatment.
12.  Other - (specify medical disorder and resultant restrictions of mobility): \_\_\_\_\_  
\_\_\_\_\_
13.  Applicant does not have any of the above disorders, and is not eligible.

I hereby certify, under penalty of perjury, that this application is true and correct to the best of my knowledge and that I am a California licensed (check one):

- Physician       Rehabilitation Counselor       Clinical Social Worker       Psychologist

I have completed this application by checking all applicable disabilities and recommend that the City of Pico Rivera allow applicant Disabled status for Dial-a-Ride:

- Temporary Disability (minimum of three months)       Permanent Disability  
 3 Months       6 Months       9 Months       12 Months       other (specify)

\_\_\_\_\_  
**Physician Signature and Title**

\_\_\_\_\_  
**Date**

*The City of Pico Rivera reserves the right to make final determination of eligibility in case of dispute. This application is for internal use only and will not be subject to public review.*

**PLEASE RETURN COMPLETED FORM TO:  
PICO RIVERA SENIOR CENTER, 9200 MINES AVENUE, PICO RIVERA, CA 90660  
(562) 948-4844 - Attention: Natalie Glasman  
\*Applicant MUST come in to have their picture taken\***