Application for the Dial-A-Ride

All applications are accepted Monday through Friday from 7:30 AM to 4:30 PM by either Mail, Email, or Drop off to:

EC Rider
600 Transit Way, Fort Walton Beach, FL 32547
Phone: (850) 833-9168
Email: dltransit@myokaloosa.com

This section must be completed by all applicants

GENERAL INFORMATION (PLEASE PRINT)

Date of Birth: ____ / ____ / _____ **(AGE IS NOT USED FOR PARATRANSIT ELIGIBILITY DETERMINATION)**

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____ **Apt. #** _____

City: _____ **ST:** _____ **Zip Code:** _____

Home Phone: ( ) _____ - _____ **Cell Phone:** ( ) _____ - _____

Email: _____

Do you live in a (Please select one of the following)

☐ **House** ☐ **Apartment** ☐ **Nursing Facility** ☐ **Assisted Care Living Facility** ☐ **Other**

Is a gate code required for entry? ☐ **YES** ☐ **NO** **Code Number** _____

Subdivision and / or Facility Name: _____

Is your home address also your mailing address ☐ **YES** ☐ **NO**

Mailing Address: _____ **Apt. #** _____

City: _____ **ST:** _____ **Zip Code:** _____

Emergency Contact:

Name: _____ **Relationship:** _____

Phone: ( ) -

CURRENT TRANSPORTATION

Do you currently use the fixed route system? ☐ **YES** ☐ **NO** ☐ **Sometimes**

If yes what routes _____

If no, please explain _____

Can you get to the bus stop by yourself? ☐ **YES** ☐ **NO**

If no please explain _____

Can you board the bus by yourself? ☐ **YES** ☐ **NO**

If no please explain _____

If travel training was offered, would you be interested in receiving training for the fixed route services? ☐ **YES** ☐ **NO**

If you are found eligible for Dial-A-Ride Services, will you?

- ☐ Need assistance from your door
- ☐ Need assistance from the vehicle to the door to your destination

Please check the reason you are applying for the Dial-A-Ride Program

- ☐ The bus stop is too far (more than ¾ mile).
- ☐ The bus does not run where I need to go/when I need to go for employment, appointments, etc.
- ☐ I have a disability that prevents me from using the fixed route bus service

ASSISTIVE DEVICES USED

TO ENSURE THE BEST SERVICE, PLEASE CHECK OR LIST ANY SPECIAL ACCOMMODATIONS YOU USE WHILE BEING TRANSPORTED

NONE NEEDED	_____	Cane	_____	Service Animal	_____
Power Wheelchair	_____	Walker	_____	Companion Rider	_____
Manual Wheelchair	_____	Extra-Wide Wheelchair	_____	Scooter	_____
Stretcher	_____	Respirator	_____	Prosthesis	_____

Special Wheelchair _____ Other _____

Do you Require a lift to board the bus? ☐ **YES** ☐ **NO**

ECRider may to be able to accommodate you if you mobility device is wider than 30 inches or longer than 48 inches or if your total weight when occupying you mobility device exceeds 600 pounds.

DISABILITY INFORMATION

What type or types of disabilities prevent you from using ECRider fixed route buses?

☐ Physical Disability ☐ Developmental Disability ☐ Visual Impairment/Blindness

☐ Mental Disability ☐ Other/Explain _____

Is the disability described above temporary or permanent?

☐ Permanent ☐ Temporary If Temporary, explain duration until: _____

☐ I do not know

PERSONAL CARE ATTENDANT

Do you require the assistance of a Personal Care Attendant?

☐ Always ☐ Sometimes ☐ Never

Please note: A Personal Care attendant is not provided by ECRider. If eligible, ECRider may require you to travel with your own Personal Care Attendant if your condition or disability is severe.

MEDICARE/MEDICAID

Does the applicant have Medicare or Florida Medicaid? ☐ **YES** ☐ **NO**

If yes, please submit a copy of the Medicare or Florida Medicaid card.

Dial-A-Ride is not a Medicaid or Medicare transportation provider. Some Florida Medicaid and Medicare programs provide transportation services to their enrollees at no cost or little cost to the beneficiary. Depending on the program If you are not sure whether your Florida Medicaid or Medicare program provides transportation services, please contact them

Is this application for a disabled child? ☐ **YES** ☐ **NO**

If yes, does the child have Medicare or Florida Medicaid? ☐ **YES** ☐ **NO**

If yes, please submit a copy of the child's Medicare or Medicaid card.

IF THE APPLICANT IS DISABLED AND UNABLE TO RIDE A FIXED ROUTE BUT DOES NOT HAVE MEDICARE OR FLORIDA MEDICAID, A MEDICAL VERIFICATION FORM SHOULD BE COMPLETED BY YOUR DOCTOR AND SUBMITTED FOR APPROVAL. PLEASE REQUEST THE FORM FROM THE EC RIDER OFFICE.

VERIFICATION OF ELIGIBILITY

THIS FORM MUST BE COMPLETED BY QUALIFIED LICENSED PROFESSIONAL

PLEASE PRINT

Person Completing Application: _____

Professional Title: _____ Agency/Affiliation: _____

Business Address: _____ **Apt. #** _____

City: _____ **ST:** _____ **Zip Code:** _____

Business Phone: **(** **)** _____ **-** _____ **Fax:** **(** **)** _____ **-** _____

State of Florida Professional License/Certification Number **(REQUIRED):** _____

If you mark NO to any of the numbered items below, please explain.

1.- What is the medical diagnosis that caused the disability (e.g. Mental Retardation, epilepsy)?

_____

_____

Is applicant's condition temporary?

☐ Yes If YES, expected duration-until: _____
Date of Duration

☐ No

2.- Does the applicant's disability require that he or she travel with an attendant?

☐ Yes

☐ No

3.- Is there any other medical information ECRider should know in the even of an emergency?

_____

_____

DISABILITY AFFECTING MOBILITY AND VISION IMPARED

4.- Is the applicant able to:

Travel a distance of 200 feet without assistance?

☐ Yes

☐ No Explain: _____

Travel a distance of one block (1/4 mile) without assistance over different types of terrain?

☐ Yes

☐ No Explain: _____

Able to climb three 12-inch steps without assistance?

☐ Yes

☐ No Explain: _____

Able to wait outside without support for 15-30 minutes in all weather conditions?

☐ Yes

☐ No Explain: _____

COGNITIVE DISABILITY

5.- Is the applicant able to:

Give name, address and telephone numbers upon request?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

Recognize a destination or landmark?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

Deal with unexpected situations or unexpected changes in routine?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

Ask for, understand, and follow directions?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

Please describe any other functional limitation(s) affecting mobility not describe above. Please be specific

_____

_____

_____

SPEECH IMPAIRED

6.- Is the applicant able to:

Communicate verbally?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

Communicate in writing?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

Communicate over the phone?

☐ Yes

☐ No Explain: _____

☐ Sometimes Explain: _____

SIGNATURE OF QUALIFIED LICENSED PROFESSIONAL

I HEREBY CERTIFY under penalty of perjury under the laws of the State of Florida that the information provided above for verification of eligibility is true and correct.

_____ _____

Signature of Qualified Licensed Professional Date

INCOME VERIFICATION

TRANPORTATION DISADVANTAGED PROGRAM ONLY

Is the applicant employed? ☐ **YES** ☐ **NO**
If yes, please provide two (2) most recent pay stubs

If married, is the spouse employed? ☐ **YES** ☐ **NO**

Do you receive SSI or SSDI? ☐ **YES** ☐ **NO**
If yes, please submit a copy of the award letter

Total Number of Members in Household? _____

What is your monthly income? **$** _____

What is the total household income? **$** _____

CERTIFICATION AND ACKNOWLEDGEMENT

I understand and affirm that the information contained in this application for Transportation Disadvantaged financial and transportation assistance is true and correct to the best of my knowledge and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility of transportation to and from eligible services and appointments. I understand that providing false, incomplete, or misleading information making fraudulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida

I also understand that Transportation Disadvantage costs depend on the distance traveled and **payment is due to the driver (cash or coupons only) as soon as I board the vehicle and cannot be billed. I also understand that trips are subject to availability and are NOT guaranteed.**

Applicant Signature _____ **Date:** ____ / ____ / _____

If Applicant is unable to sign
Signature of Authorized Personnel/Title _____ **Date:** ____ / ____ / _____

If Applicant is under 18
Signature of Parent/Guardian _____ **Date:** ____ / ____ / _____