LONG BEACH TRANSIT

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

☐☐☐ ☐☐☐ ☐☐☐☐

2nd Phone Number

SECTION 2: Mailing Address

____

Street Address Apt. #

____

City State Zip

Emergency Contact

Name:____ Relationship: ______________

Phone:_______________________________________

SECTION 3: 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

LONG BEACH TRANSIT

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)

☐ Not applicable
☐ I cannot travel to an unfamiliar place
☐ Distance to public transit bus is too far
☐ No paved sidewalks
☐ Extreme Cold
☐ It is inconvenient for me to travel by public transit bus
☐ I cannot afford the cost of taking the bus
☐ I fear travelling by public transit bus
☐ No curb cuts
☐ Street with Hill
☐ Extreme Heat

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

_________RENEWAL
________ APPROVED
________ DENIED
REASON FOR DENIAL____

SIGNED____DATE_________________________

Dial-A-Lift

Physician's Statement

Long Beach Transit's (LBT) Dial-A-Lift (DAL) services are only available to those with severe and permanent mobility impairments, LBT DAL requests a physician to assess and verify an applicant's disability in order to determine the appropriate transportation service for each individual.

Please include a brief description of the patient's mobility impairment(s) that would prevent the patient from using LBT's fixed-route bus system.

Patient's name: ____

Physician's name: ____

Telephone: ____

Address: ____

☐ Temporary / Duration ________ Month(s) _______Year(s) ☐ Permanent

I certify that I am a licensed physician in the State of California.

Signature: ______________________________Date____________________

Please describe the patient's mobility impairment(s):

____

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This Physician's Statement is valid for 6 months after the signed date