Santa Ynez Valley Transit Dial-A-Ride Application Form

Please send application form with photocopy of state-issued ID to:
Attn: ADA Coordinator
Santa Ynez Valley Transit
595 Alamo Pintado Rd., Suite C
Solvang, CA 93463

Last Name: ________________________ First Name: ________________________ Date of Birth: ____/____/_____

Home Address: ____

Mailing Address (*if different from home address*)_____________________________________

Telephone Day (   ) _______________ Telephone Evening (   ) ______________ | Sex: ❒ Male ❒ Female

Are you over the age of 60? ❒ Yes ❒ No **Are you disabled?** ❒ Yes ❒ No
Please provide photocopy of a state issued ID card with this application.

TTY/TTD (Hearing-Impaired) ❑ Yes ❑ No

Please check all that apply when traveling:

- ❑ Restricted to wheelchair
  - *If restricted to a wheelchair, is it motorized?*
    - ❒ Yes
    - ❒ No
- ❑ Use of walking cane, walker, or crutches
- ❑ Personal care attendant
- ❑ Service animal
- ❑ Oxygen tank

Do you need to have information and materials provided to you in any of the following forms? (check all that apply)

- ❑ Large print
- ❑ Audio
- ❑ Other: ________________________________

Please provide the name and telephone number of someone we may contact in the event of an emergency:
Name: ____ Relationship: ______________________

Address: ____

Telephone Day (   ) _______________ Telephone Evening (   ) _______________

ONLY COMPLETE THIS SECTION IF YOU HAVE A DISABILITY

This section to be completed by applicant's Physician only.

Physician's Name: ______________________________________ Phone (   ) ___________________

Address: ____

What type of disability does the applicant have? (check all that apply)

- ❑ Physical disability
- ❑ Visual impairment
- ❑ Developmental disability
- ❑ Mental illness
- ❑ Other:__________________________
- ❑ None

Is the applicant's disability: ❒ Temporary ❒ Permanent

If temporary, what is the estimated date said disability would end: _____/______/______
I certify that the eligibility information contained in this document is true and correct.

_____________________________________ _____/_____/_____
Physician's Signature Date

OFFICE USE ONLY

❒ Approved: Permanent/Senior
❒ Temporary (until) date: _____/_____/_____
❒ Denied

By: __________________________________
Date: _____/_____/______

For Dial-A-Ride information call (805) 688-5452

Aplicación Para Santa Ynez Valley Transit Dial-A-Ride

Por favor envíe la aplicación con una copia de su identificación proporcionado por el estado a:
Attn: ADA Coordinator
Santa Ynez Valley Transit
595 Alamo Pintado Rd., Suite C
Solvang, CA 93463

Apellido: ______________________ Nombre: ______________________ Fecha de Nacimiento: ___/___/_____

Dirección de hogar: ____
Dirección de Correo (*si es diferente de su hogar*)________________________________

Teléfono de Día (   ) __________ Teléfono de Noche (   ) __________ | Género: ❒ Hombre ❒ Mujer

¿Eres mayor de 60 años de edad? ❒ Sí ❒ No
¿Eres discapacitado? ❒ Sí ❒ No
Por favor envíe una copia de su identificación proporcionado por el Estado.

TTY/TTD (deficientes auditivos) ❑ Sí ❑ No

Por favor indica cuales aplican cuando viajando:
- ❑ Limitado a silla de ruedas
  Si limitado a silla de ruedas, ¿es motorizado?
  - ❒ Sí
  - ❒ No
- ❑ Uso de bastón, andador, o muletas
- ❑ Asistente personal
- ❑ Animal de servicio
- ❑ Tanque de oxigeno

¿Se necesita tener la información y los materiales proporcionados a usted en cualquiera de las siguientes formas? (indica todas cuales aplican)
- ❑ Letra grande
- ❑ Audio
- ❑ Otro: ______________________

Por favor proporciona el nombre y número de teléfono de alguien quien podemos contactar en evento de emergencia:
Nombre: ________________________________ Relación: ____________________

Dirección: ____

Teléfono de Día (   ) ____________ Teléfono de Noche (   ) ____________

SOLAMENTE COMPLETA ESTA SECCION SI TIENES UN DISCAPACIDAD

Esta sección debe ser completada solamente por el médico del solicitante.

Physician Name: ______________________________ Telephone (   ) ______________

Address: ____

What type of disability does the applicant have? (check all that apply)
- ❑ Physical disability
- ❑ Visual impairment
- ❑ Developmental disability
- ❑ Mental illness
- ❑ Other:____________________
- ❑ None

Is the applicant's disability: ❒ Temporary ❒ Permanent

If temporary, what is the estimated date that disability will end: _____/______/______
I certify that the eligibility information contained in this document is true and correct.

______________________________ _____/_____/_____
Physician's Signature Date

SOLAMENTE POR USO DE LA OFICINA

❒ Approved: Permanent/Senior
❒ Temporary (until) date: _____/_____/_____
❒ Denied

By: ______________________________
Date: _____/_____/______

Para información de Dial-A-Ride llame al (805) 688-5452