

# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

# 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  
TTY/TTD (deficientes auditivos)  
 Sí  No

**Por favor envíe una copia de su identificación proporcionado por el Estado.**

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 oxígeno

¿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: \_\_\_/\_\_\_/\_\_\_