

ISLAND TRANSIT/ DEMAND RESPONSE DIAL-A-RIDE
APPLICATION FOR CERTIFICATION OF ELIGIBILITY

Dear Physician/Certified Health Professional:

We are requesting your assistance so that we can determine whether the undersigned applicant is eligible for Island Transit Demand Response bus services. Island Transit Demand Response is a curb-to-curb bus service for people whose disability prevents them from using the local fixed route Island Transit bus system for one of the following reasons:

Passenger is unable, without the assistance of another person, to board, ride or disembark from an accessible local Island Transit bus. This includes people who, due to a severe impairment, are unable to “navigate” the bus system even with medication or corrective lenses.

Passenger is prevented from getting to and from the bus stop, based on a disabling condition. Eligibility is not available on the basis of increased safety, convenience, or based on distance to the bus stop alone (the physical limitation must be the determining factor.)

Please render judgment whether the applicant, in your professional opinion, can or cannot access an accessible bus due to severe functional disability. We have provided a space below for you to describe in layman terms that applicant’s disability, and how their disability prevents use of the local fixed route bus service. Detailed information will help Island Transit make the property eligibility determination.

Thank you.

Please Print or Type

Important: Please sign the application card below and provide an additional signature on your professional letterhead or prescription note to help us prevent fraudulent applications. The application *cannot* be processed without all requested information and both signatures.

1) Patient/Client name: (Please print or type)

2) Describe completely the medical condition (Please print or type)

How does the medical condition prevent local fixed route bus usage? (Please print or type)

3) Check One

Permanent Temporary, If temporary, please specify how many months _____

4) Does applicant use any of the following aids for mobility?

Manual Wheelchair	Electric-Wheelchair	Cane	Guide/Service Dog
Crutches	Powered Scooter	Walker	Personal Care Attendant

5) Professional’s Name: (please print or type)

Telephone Number:
()

6) Physician/Certified Health Professional’s Signature

X _____ Date: _____

I hereby certify that I have read and understand the eligibility requirements for the Island Transit Demand Response bus service as stated on the above letter and certify that my patient cannot ride an accessible local fixed route bus.

**ISLAND TRANSIT/ DEMAND RESPONSE DIAL-A-RIDE
APPLICATION FOR CERTIFICATION OF ELIGIBILITY**

INSTRUCTIONS FOR APPLYING FOR ISLAND TRANSIT DIAL-A-RIDE SERVICES

To Apply you must:

1. Have your physician/certified health professional complete and sign the medical verification section of the application on the reverse side.
2. Have you physician/certified health professional submit an additional signature on his/her letterhead or prescription note verifying completion of this application form to help us prevent fraudulent applications.
3. Fill out completely and sign the applicant's portion of the application below.
4. Return the completed application form with professional's letterhead to the address below:

Remember:

Island Transit will process your completed application and notify you within 14 days after a completed application arrives in our office. Island Transit reserves the right to require additional information. Final decisions will be made by Island Transit.

If Island Transit denies the application, the applicant has the right to appeal in writing to the following address:

Return completed application form to:

<p>Island Transit 3115 Market Street Galveston, Texas 77550</p>
--

If you have any questions, please call Dial-A-Ride
(409) 797-3909 - (409) 797-3901 fax

TO BE COMPLETED BY APPLICANT			
Name of Applicant: (Nombre de Solicitante)	Last (Apellido)	First (Nombre)	Middle (Inicial) Social Security No. (Numero de Seguro Social del Solicitante)
Address: Street (Dirección: Calle)		Apartment Number (Numero de Apartamento)	City (Ciudad)
Zip Code (Código Postal)	Telephone No. (Teléfono)		Date of Birth (Fecha de Nacimiento)
Apartment Complex Name (Nombre de Apartamento)		Gate Code (Código de Cochera)	
Applicant's Signature (required) (Firma)		Date (Fecha)	
X _____		_____	