Santa Ynez Valley Transit Dial-A-Ride Application Form

Please send application form with photocopy of state issued ID to:
Attn: ADA Coordinator
City of Solvang
1644 Oak Street
Solvang, California 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 _____ (*Name and contact number of 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: _____ Relation: _____

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 that disability will 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
City of Solvang
1644 Oak Street
Solvang, California 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_____ *(Nombre y número de contacto del asistente)*
- ❑ 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