

# CITY OF DOWNEY DIAL-A-RIDE APPLICATION: PART 1



**Submit the following to process your DIAL-A-Ride membership:**

- ▶ Complete and sign the Application—Part 1
- ▶ Copy of identification with your date of birth and residential address
- ▶ Physician's Verification: Part II of Application (Only if under 65)

**IF YOU ARE UNDER 65 YEARS OF AGE YOU MUST HAVE YOUR PHYSICIAN COMPLETE THE PHYSICIAN'S VERIFICATION SECTION ON THE BACK-SIDE OF THIS PAGE.**

**PLEASE PRINT or TYPE**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: Downey Zip Code: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
 Type of Residence:  Individual  Retirement/Senior Home  Board & Care  
 Phone/Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Name of Living Facility: \_\_\_\_\_ Facility Phone Number (\_\_\_\_) \_\_\_\_\_

My Age:  I am 65 years or older  I am under 65 years of age (with a disability)  
 I am legally blind:  Yes  No  
 I always use:  Walker  Manual Wheelchair  Electric Wheelchair  Service Animal  
 I sometimes use:  Walker  Manual Wheelchair  Electric Wheelchair  Service Animal  
 I have:  Cognitive Issues  Hearing Impairment  Difficulty Communicating  
 I require a self-provided escort:  Always  Sometimes (Conditional escort)  Never  
 Other \_\_\_\_\_  
 I speak:  English  Spanish  Chinese  Japanese  Other \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Contact 1: _____	Contact 2: _____
Relationship: _____	Relationship: _____
Phone/Home: (____) _____	Phone/Home: (____) _____
Cell: (____) _____	Cell: (____) _____
Business: (____) _____	Business: (____) _____
Email: _____	Email: _____

**STATEMENT OF CONSENT/ACKNOWLEDGMENT**

I, the undersigned person, understand that I have chosen to voluntarily participate in the Dial-A-Ride Program at my own risk. By participating in the Dial-A-Ride Program, I, my heirs, executors, and representatives, do hereby release, discharge, waive and relinquish the City of Downey, its officers and , employees and agents, from any and all claims, demands, liability, causes of action and harm arising out of or resulting from this program. I understand that the above activity is sponsored by the Department of Community Services and that transportation shall be only in properly insured and authorized vehicles. I further indemnify and hold harmless the City, its officials, officers, employees and agents from any and all claims arising out of or incident to my participation in the program.

I have had the opportunity to ask any questions about this form by calling (562) 904-7215 and I understand that this form and the pamphlet provided to me contains the entire agreement between the parties related to my participation in the Dial-A-Ride Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail or deliver application to: Downey DIAL-A-RIDE , 8150 Nance Street, Downey, CA 90241**



**CITY OF DOWNEY  
DIAL-A-RIDE  
APPLICATION: PART 2  
PHYSICIAN'S VERIFICATION**  
(Only required for applicant's under 65 years old)

This section must be completed by an authorized California Physician

**ELIGIBILITY EVALUATION: PLEASE PRINT**

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Indicate one or more of the following disabilities that prohibit the applicant from boarding and alighting regular public transportation:

- Legally Blind     Kidney Disease     Developmentally Disabled
- Impaired by class III or class VI type cardiovascular disease as defined by the American Heart Association.
- Suffers from lung disease such that measured force respiratory volume for one second is less than 1L or arterial oxygen tension is less than 60mm/Hg on room air at rest.
- Other—Explain disabilities in detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DURATION AND DEGREE OF DISABILITIES**

The disability is:     Permanent     Temporary

If temporary, please indicate the length of disability:

- 1—2 months     2—4 months     4—6 months (\*After 6 months, physician's re-verification is required.)

**PHYSICIAN'S INFORMATION**

Physician's Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

*I hereby certify that I am a licensed physician of the State of California, have knowledge of this applicant, and recommend that the applicant be certified to use the City of Downey DIAL-A-RIDE because of the aforementioned disability which prevents the applicant from using regular transit services. (Example: Metro, DowneyLINK, etc.)*

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please answer all questions by filling out blank lines and checking all boxes that pertain to the application.**

If you have any questions, call the DIAL-A-RIDE administration office at (562) 904-7215.

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