



DOWNEY DIAL-A-RIDE APPLICATION: PART 1

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

PLEASE PRINT

Name: _____ Date of Birth: _____ Male Female
 Address: _____ City: _____ 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: _____

I assume full responsibility for and release the City of Downey from any liability for my safety and well-being before I board and after I exit the DIAL-A-RIDE vehicle.

Signature: _____ Date: _____

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

- ▶ Complete Application
- ▶ Copy of identification with your date of birth and residential address
- ▶ Physician's Verification: Part II of Application (only if under 65 years old)

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.





**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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