

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
431 Second St., Suite 9
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
- 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: ____/____/____

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
431 Second St., Suite 9
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

TTY/TTD
(deficientes auditivos)

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

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
- 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: ____/____/____