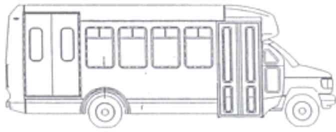
SMAT USE ONLY
_____New ____Renewal
Date Approved_________
Card #________________
Date Issued ___________
Expiration Date ________

CITY OF SANTA MARIA

SANTA MARIA AREA TRANSIT



APPLICATION FOR CERTIFICATION FOR SUPPLEMENTAL SERVICE UNDER THE AMERICANS WITH DISABILITIES ACT OF 1990 (ADA)

Please type or print your answer.

Name____

Address____

City____________________________ State________________Zip_______________

Telephone: Home_____________________Work_______________________

Social Security Number*____

Language Spoken* ____Espanol _____English _____Other (___________)

Date of Birth*___________________Age___________Male ☐ Female ☐

Emergency Contact Name_____________________Relationship__________________

Daytime Phone___________________ Evening Phone_________________________

**Optional – The Federal privacy act of 1974 requires that you be notified that disclosure of your social security number is voluntary; however, it may be used as part of your identification number.*

1. What is the nature of your disability or condition that you feel makes you eligible for supplemental ADA service? (Check all that apply).

- ☐ Cardiovascular Impairment
- ☐ Developmental Disability
- ☐ Difficulty Walking
- ☐ Hearing Disability
- ☐ Wheelchair User
- ☐ Mental/Cognitive Disability
- ☐ Musculo-Skeletal Disability
- ☐ Neurological Disability
- ☐ Respiratory Impairment
- ☐ Seizure Disorder

- ❑ Visual Disability
- ❑ Other Disability (Please Specify)

____

2. Has your disability been documented by a medical doctor?

   If yes, please state diagnosis (if known)

   ❑ Yes ________________________________

   ❑ No

3. Since when have you had this disability or condition? ___/___/_________

4. Is this disability or condition temporary?

   ❑ Yes If yes, expected duration until ____/____/________

   ❑ No

5. Please describe how your disability/condition limits your ability to use the regular fixed route system. (If available, please attach professional letters or other documentation you may have concerning your disability.)

   ____

   ____

   ____

   ____

6. Are you able to complete any of your trips on the fixed route system?

   ❑ Yes ____

   ____

   ❑ No. Please explain____

   ____

7. Are you able to independently get to and/or from a regular bus stop?

   ❑ Yes ____

   ____

   ❑ No. Please Explain ____

   ____

8. Are you able to independently get on and/or off a regular fixed route bus?

❑ Yes ____

____

❑ No. Please Explain ______________________________________

____

9. Which of these mobility aids or equipment do you use to help you get where you need to go?

❑None	❑Manual Wheelchair	❑Service Animal
❑Cane	❑Power Wheelchair	❑Picture Board
❑White Cane	❑Powered Scooter/Cart	❑Alphabet Board
❑Walker	❑Portable Oxygen	❑Crutches

Other ____

10. What is the combined weight of you and your wheelchair – approximate?

_____________ Pounds

11. How far can you continuously walk or move your wheelchair?

(Example, 1 mile, 30 minutes) ___________________________

12. Do you require an aide or attendant to use the fixed route bus system?

❑ Yes

❑ No

13. If yes to either question 11 or 12, has an agency or medical doctor recommended the use of an aide or attendant?

❑ Yes

❑ No

APPLICATION SIGNATURE

I hereby certify that the information given above is complete and correct to the best of my knowledge. I understand that if *I am* not found to be eligible for ADA supplemental service that I may appeal determination within 60 days upon receipt of written determination, and that I will be advised of the procedures for such an appeal. I hereby authorize the certifying entity to contact any agency or professional who has been indicated on this form, by narrative or by attachment in order to verify documentation of disability.

____

Applicant Signature – or guardian if applicable Date

Once you have completed this form, please mail to SMAT office at 1303 Fairway Drive, Santa Maria, CA 93455. If it is necessary to have an interview, transportation will be provided at no charge.

PROFESSIONAL VERIFICATION FOR ____
Patient's Name

NOTE: THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING RECOGNIZED PROFESSIONALS: registered nurse, physician, social worker, psychologist, physical therapist, chiropractor, occupational therapist, speech pathologist, nurse practitioner, physician's assistant, mental health counselor, respiratory therapist, vocational counselor, or recreation therapist employed by a medical facility.

The applicant may be found eligible for SMAT ADA bus services for all trips he/she requests, or eligible (based on functional ability) for some trip requests, or eligible (based on functional ability) for some trip requests but not for others, or capable of using the regular bus. ***NOTE: All SMAT fixed route buses are equipped with a ramp or lift for people who use a wheelchair or cannot climb stairs.*** The information you provide will enable us to make an appropriate determination for each trip request. All information will be kept confidential. Thank you for your assistance.

Capacity in which you know the applicant: ____

Physical and/or cognitive condition which functionally prevents use of lift-equipped bus: ______
____
____

Is this condition temporary? _____NO _____YES, for __________months

_____ I have reviewed all of the information contained in this application, and hereby certify that all information is true and correct to the best of my knowledge and ability.

Exceptions or Additions: ____
____
____
____
____
____

Print Name and Title ____

Signature ___________________________________ Date ____________________________

Clinic/Agency ________________________________ Phone ___________________________

Address ____________________________________ City _____________________________