



Application for SunDial Paratransit Service

Informational Sheet

Thank you for inquiring about eligibility for SunLine Transit ADA Paratransit eligibility. SunLine offers multiple public transportation options for people with disabilities. Eligibility for these service is based on an individual's functional inability to use SunLine's fixed-route SunBus service due to a disability.

SunLine operates the SunBus fixed-route service, which is designed to serve all riders, including individuals with physical, cognitive, or visual disabilities. All SunLine buses are equipped with ADA-accessible features such as low-floor entry, lifts or ramps, audio announcements, designated priority seating, enhanced signage, kneeling capability, and handrails.

SunLine also provides the SunDial Paratransit Service for customers with disabilities who are functionally unable to use the SunLine fixed-route bus services. If you are functionally unable to use the fixed-route bus service, you may be eligible for the SunDial service. SunDial is a public transportation paratransit service for customers with disabilities who are unable to use the fixed-route bus system. Concerns such as diagnosis, age, distance to bus stop, lack of bus service, overcrowded buses, inability to drive, personal finances, inconvenience, and/or discomfort are not the sole basis of SunDial's eligibility determination.

SunDial is provided in accordance with the Americans with Disabilities Act (ADA) and is an origin to destination, shared ride, advanced reservation public transit service. Consistent with the ADA, SunDial is comparable to SunLine's fixed-route bus system including service characteristics (such as on time performance and travel time) and service area (¾ mile of a regular SunLine fixed bus or route).

Paratransit Service: SunDial



SunDial FARE

MUST MEET SUNDIAL ELIGIBILITY CRITERIA	
TRAVEL WITHIN SAME CITY	\$1.50 ONE-WAY PER PERSON
TRAVEL WITHIN MULTIPLE CITIES	\$2.00 ONE-WAY PER PERSON



Fixed-Route: SunBus



SunBus FARES & PASSES

	Single Ride Fare	Day Pass
ADULT	\$1.00	\$3.00
YOUTH	\$0.85	\$2.00



Application for SunDial Paratransit Service

HOW TO APPLY:

1. Review the eligibility information supplied on this ADA application.
2. If you believe you qualify for ADA paratransit services:
 - a. Complete **entire ADA paratransit application Part A.**
 - b. **SIGN THE APPLICATION**
 - c. Have a medical professional familiar with your health condition or disability and your functional abilities and limitations complete the **Health Care Provider Certification Form – Part B** of the application. **The Health Care Certification Form** must be completed within **60 days prior** to applying. (it may not be signed by health care provider more than 60 days before turning it back in to SunLine Transit Agency.)
3. **When you have completed both sections, Parts A and B, please mail them to:**
 - a. MAIL:

SunLine Transit Agency
c/o ADA Eligibility
32505 Harry Oliver Trail
Thousand Palms, CA 92276

Before I start this application and the certification process, I understand all information provided must be true, accurate, and correct. I hereby certify that, to the best of my knowledge, information given in this application is correct. The purpose of this application is to determine if I am eligible to use paratransit services, or if at times, I can ride the SunLine fixed-route bus service. I understand that falsification of information could result in a loss of paratransit services as well as a penalty under the law.

Parts A and B must be submitted together to start the process. An incomplete application will be returned to the applicant and may delay processing. Every question must be answered and be legible.



Application for SunDial Paratransit Service

PART A: Applicant Information and Release

Personal Data

First Name: _____ Middle Name: _____

Last Name: _____

Date of Birth: _____

Home Phone: _____ Mobile Phone: _____ Other Phone: _____

Do you require TDD services? ☐ Yes ☐ No

Email Address: _____

Home Address: _____

City: _____ State _____ Zip _____

Mailing Address: _____

City: _____ State _____ Zip _____

Gate Code: _____ Apartment/Residential Name: _____

If recertification: ☐ New Application ☐ Recertification

SunDial ADA Number: _____ Exp. Date: _____

Please give us the name and phone number of a friend or relative we can call in case of emergency or if we are unable to reach you at your regular number:

First Name: _____ Last Name: _____

Phone: _____ Other Phone: _____

Relationship: _____

OFFICE USE ONLY

- ☐ Unconditional ☐ Conditional
☐ In Service Area ☐ Outside Service Area
☐ Recertification ☐ New Client

ADA # _____ Exp. Date _____
Packet Sent ☐ Scanned ☐ Attached ☐ Tracked



Application for SunDial Paratransit Service

Transit Usage

1. Do you currently use fixed-route (large public) buses independently? ☐ Yes ☐ No ☐ Sometimes

2. When was the last time you rode the fixed-route bus? _____

3. How frequently do you ride the fixed-route bus? 3. _____ per month

Which fixed-route bus routes do you currently use?

4. Have you ever had travel training to learn how to travel around the community and/or on how to use fixed-route buses? ☐ Yes ☐ No

5. Would you like information about travel training to use the fixed-route buses? ☐ Yes ☐ No

Disability/Health Condition Information

All questions must be answered.

6. Please describe the disability or health condition which prevents you from using fixed-route buses.

8. Is this a temporary disability or health condition? ☐ Yes ☐ No

9. If yes, how long you do expect it to prevent you from using fixed-route bus service? _____ Months



Application for SunDial Paratransit Service

10. Are you currently receiving any treatment?

☐ Yes

☐ No

If yes, check what treatment(s) apply to you:

☐ Medications

☐ Physical Therapy

☐ Chemotherapy

☐ Radiation Therapy

☐ Dialysis

☐ Psychotherapy

☐ Non-weight Bearing Immobilization

☐ Surgery

☐ Rehabilitation

☐ Weight Bearing Immobilization

☐ Convalescence

☐ Other: _____

11. How long will you be receiving treatment?

☐ < 3 months

☐ 3-6 months

☐ 6-9 months

☐ 9-12 months

☐ > 12 months

☐ Unknown duration

13. Have you had a recent fall which required medical attention?

☐ Yes

☐ No

If yes, what is your fall frequency per week?

If yes, did the fall occur while using mobility aid/device?

☐ Yes

☐ No

14. Do you live in an assisted living facility or nursing facility?

☐ Yes

☐ No

15. Do you ever need to bring someone with you to help you when you travel (a "personal care assistant" or "personal attendant")?

☐ Yes

☐ No

16. Do you use any mobility aids or equipment? (check all that apply)

☐ Powered/Electric Wheelchair

☐ Manual Wheelchair

☐ Powered Scooter

☐ Walker

☐ Cane

☐ Communication Board

☐ Brace

☐ Prosthesis

☐ Portable Oxygen in Cart

Type of Brace: _____

☐ Service Animal

☐ Portable Oxygen in Bag

☐ White Cane

☐ Crutches

☐ None

☐ Other: _____

17. If you use a wheelchair or scooter, what is the width and length?

Width: _____ inches

Length: _____ inches

18. If you use a wheelchair or scooter, what is the total weight of your mobility device when you are using it?

Weight: _____ pounds

If your wheelchair or scooter is larger than 30 inches wide, 48 inches long and 600 pounds when occupied, the SunLine paratransit vehicle may be unable to accommodate your trip.



Application for SunDial Paratransit Service

Transit Skills

Please read the following statements and check those which best describe your abilities to use fixed-route buses (**check all that apply**). **At least one box needs to be checked.**

- ☐ I can get to and from bus stops if the distance is not too great.
- ☐ I can ride buses when I am feeling well. There are other times, when my disability or health condition worsens, that I cannot ride the buses.
- ☐ I have a disability or health condition that prevents me from riding the buses and if the weather is very hot or cold.
- ☐ My disability or health condition makes it impossible to travel when there is snow or ice on the ground.
- ☐ I can get to and from bus stops only if there are curb cuts and sidewalks.
- ☐ I can get to and from bus stops and light only if there are no hills.
- ☐ I have difficulty understanding or remembering all the things I would have to do to use the buses.
- ☐ I can use the buses if it is someplace that I go all of the time.
- ☐ I can never use buses by myself.
- ☐ I am not sure if I can use buses.
- ☐ I am not able to use buses for other reasons.

If you checked any of the above boxes, please explain:

Functional Skills

The following questions will give us more information about your functional abilities. Please select Always (A), Sometimes (S), or Never (N) in response to the following questions and provide an explanation.

	Always	Sometimes	Never
Without the help of someone else can you:			
Ask for and understand written or spoken instructions?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
<i>If Sometimes or Never, please explain:</i>	<hr/>		
Cross the street?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
<i>If Sometimes or Never, please explain:</i>	<hr/>		
Stand for 15 minutes if there is no place to sit?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
<i>If Sometimes or Never, please explain:</i>	<hr/>		



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Always Sometimes Never

Step on and off a sidewalk from a curb?

☐ A ☐ S ☐ N

If Sometimes or Never, please explain: _____

Walk up and down three steps if there is a handrail?

☐ A ☐ S ☐ N

If Never, please explain: _____

Walk on uneven surfaces?

☐ A ☐ S ☐ N

If Never, please explain: _____

Stand on a moving bus if there is a handrail?

☐ A ☐ S ☐ N

If Never, please explain: _____

Transfer from one bus to another?

☐ A ☐ S ☐ N

If Never, please explain: _____

Under the best conditions, what is the farthest that you can travel outdoors (using your mobility aid if you use one) without the help of another person? ☐ < 1 block ☐ 1-4 blocks ☐ > 4 blocks

Please provide any other information about your disability or health condition that would help us better understand your travel abilities:

Certification

I hereby certify that, to the best of my knowledge, information given in this application is correct. The purpose of this application is to determine if I am eligible to use paratransit services (SunDial), or if I can ride the SunLine fixed-route buses. I understand that falsification of information could result in a loss of paratransit services as well as a penalty under the law. I agree to undergo an in-person assessment of my mobility abilities and limitations for the purpose of making a determination regarding my eligibility for paratransit service. I understand that intentionally providing false or misleading information or a refusal of an in-person assessment is grounds for a determination of ineligibility for SunDial services and benefits. I agree to notify SunLine if my condition changes, if I am using a new mobility device, or if I no longer need to use ADA paratransit service.

Applicant/Responsible Party Signature: _____ Date: _____



Application for SunDial Paratransit Service

Authorization for Release of Information

I _____ authorize my health care professional to release any and all information about my disability or health condition and its effect on my ability to travel on the SunLine fixed-route system (**Part B**). I understand that I may revoke this authorization at any time. I understand that SunLine Staff may contact the health care professional who completed the verification attached to this application, in order to confirm this information. I understand that all medical information will be kept strictly confidential.

Applicant/Responsible Party Signature: _____ Date: _____

If someone assisted in completing this application, please provide the following information:

Print Name: _____

Agency (if applicable): _____

Relationship to Applicant: _____

Address: _____

Home Phone: _____ Other Phone: _____

Signature: _____ Date: _____



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SunLine also provides the SunDial Paratransit Service for customers with disabilities who are functionally unable to use the SunLine fixed-route bus services. If you are functionally unable to use the fixed-route bus service, you may be eligible for the SunDial service. SunDial is a public transportation paratransit service for customers with disabilities who are unable to use the fixed-route bus system. Concerns such as diagnosis, age, distance to bus stop, lack of bus service, overcrowded buses, inability to drive, personal finances, inconvenience, and/or discomfort are not the sole basis of SunDial's eligibility determination.

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Paratransit Service: SunDial



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 - b. **SIGN THE APPLICATION**
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Parts A and B must be submitted together to start the process. An incomplete application will be returned to the applicant and may delay processing. Every question must be answered and be legible.



Part B: Health Care Provider Certification

All information must be filled out.

Please note the following licensed health care professionals are authorized to fill out the application:

- Physician (MD or DO)
- Registered Nurse
- Psychologist
- Psychiatrist
- Ophthalmologist
- Optometrist (visual disabilities only)
- Physical Therapist
- Occupational Therapist
- Other licensed Health care provider familiar with the applicant's condition

Your patient _____ has requested eligibility for SunDial Paratransit Service. SunDial is an origin to destination, shared ride paratransit service for people whose disabilities or health conditions prevent them from riding the fixed route accessible transportation system all, or part of the time. As the applicant's healthcare provider, you are uniquely qualified to clarify the applicant's functional abilities and limitations to ride the SunLine fixed route bus system (SunBus). In order to determine this applicant's functional abilities, we require you, the healthcare provider, to complete and certify all of the following sections. Please detail how the applicant's disability (ies) or health condition(s) impact his or her ability to board, navigate, and travel independently on the accessible fixed route system. Please be as specific as possible.

The following factors do not, by themselves, qualify a person for paratransit:

- Diagnosis
- Age
- Distance to bus stop
- Lack of bus service
- Inability to drive
- Personal finances
- Inconvenience
- Discomfort

Please be advised that all SunLine buses are equipped with ADA accessible features, such as low floor buses, lifts/ramps, audio announcements, designated priority seating areas for people with disabilities, enhanced signage, kneeling buses, and hand rails.

The information shared will be protected per the requirements identified in the Health Insurance Portability and Accountability Act (HIPAA) and your patient/client has agreed in the release of information. Your patient/client has also authorized the release of further information as needed.

An incomplete application will be returned to the applicant and may delay processing. Every question must be answered and be legible.

Health Care Provider (please print): _____

Institution/Facility/Agency Name: _____

License Number: _____

State Issued: _____

Specialization: _____

Street Address: _____

City/State/Zip: _____

Phone: _____

Email Address: _____

The entire Part B form must be completed by a licensed health care provider; otherwise, the form will be denied.



Part B: Health Care Provider Certification

All information must be filled out.

- Written diagnosis(es) and ICD-9CM and/or DSM Code(s): _____
- How long have you been treating the patient? _____
- When was the last time you saw the patient? _____
- What is the expected duration of the disability? ☐ Short Term ☐ Long Term
Short Term: Conditions lasting at least 90 days but are likely to improve within one year
Long Term: Conditions with absolutely little expectation of improvement
- In your opinion, does this applicant's disability(ies) prevent him or her from independently using the accessible SunLine fixed route bus service (SunBus)?
☐ Yes (Answer question 6, if left blank, application will be denied.) ☐ No
- If yes, explain **how** the disability or health condition impacts the applicant's ability to travel independently on the accessible SunLine fixed route bus system (SunBus):

SunDial: Paratransit Service



SunDial FARE	
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Fixed-Route: SunBus



SunBus FARES & PASSES		
	Single Ride Fare	Day Pass
ADULT	\$1.00	\$3.00
YOUTH	\$0.85	\$2.00



Part B: Health Care Provider Certification

All information must be filled out.

7. Does the applicant require any of the following mobility aids/devices (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Powered/Electric Wheelchair | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Powered Scooter |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Cane | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Brace | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Portable Oxygen in Cart |
| Type of Brace: _____ | <input type="checkbox"/> Communication Board | <input type="checkbox"/> Portable Oxygen in Bag |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Service Animal | <input type="checkbox"/> None |
| <input type="checkbox"/> Other: _____ | | |

8. If this applicant is currently on medication(s), will the side effects significantly reduce or hinder his/her ability to independently ride the accessible SunLine fixed route bus service?

- ☐ Yes ☐ No ☐ N/A

9. If you selected yes, please explain how the side effects would hinder their ability to use the accessible SunLine fixed route bus service:

For questions 10-22, select Yes (Y), No (N), or Sometimes (S). If you answer Yes or Sometimes to questions 10-22, elaborate on how it prevents the applicant from using accessible SunLine fixed route bus service:

10. Would temperature extremes affect this applicant's ability to ride fixed route bus service? ☐ Y ☐ N ☐ S

Please Explain: _____

11. Would ice and/or snow affect this applicant's ability to ride fixed route bus service transit? ☐ Y ☐ N ☐ S

Please Explain: _____

12. Would poor air quality affect this applicant's ability to ride fixed route bus service? ☐ Y ☐ N ☐ S

Please Explain: _____

13. Does this applicant have any challenges with balance? ☐ Y ☐ N ☐ S

Please Explain: _____

14. Does this applicant have any challenges with memory? ☐ Y ☐ N ☐ S

Please Explain: _____

15. Does this applicant have any challenges with breathing? ☐ Y ☐ N ☐ S

Please Explain: _____

16. Does this applicant have any challenges with strength and endurance? ☐ Y ☐ N ☐ S

Please Explain: _____



Part B: Health Care Provider Certification

All information must be filled out.

17. Does this applicant have any challenges with ambulating on hills? ☐ Y ☐ N ☐ S
Please Explain: _____

18. Are there any visual impairments that would affect this applicant's ability to ride fixed route bus service? ☐ Y ☐ N ☐ S
Please Explain: _____

19. Are there any hearing impairments that would affect this applicant's ability to ride fixed route bus service? ☐ Y ☐ N ☐ S
Please Explain: _____

20. Does this applicant exhibit any inappropriate social behaviors? ☐ Y ☐ N ☐ S
Please Explain: _____

21. Do you have safety concerns for this applicant in using a bus by themselves? ☐ Y ☐ N ☐ S
Please Explain: _____

22. Does this applicant require a Personal Care Attendant when traveling? ☐ Y ☐ N ☐ S
Please Explain: _____

23. In your medical opinion, what other factors related to the applicant's disability(ies) affect his/her ability to ride the accessible SunLine fixed route service (SunBus)? (if left blank, application will be denied.)

I certify that I am legally licensed and am currently treating _____. The above information I have provided hereto is a fair representation of this applicant's disability(ies) or health condition(s) and is true and correct under penalty of perjury according to the laws of the State of California. I understand the information provided will be used for the sole purpose of determining the applicant's eligibility for paratransit service. I also agree that SunLine may contact me for clarification of any information I have provided and that I will reply with good faith. **I understand the information contained herein is true and correct to the best of my knowledge and ability. Any falsification could result in the client's loss of paratransit service.**

Signature: _____ **Date:** _____

Health care provider, please mail the completed Part B back to the applicant. Important: Parts A and B must be submitted together to begin the process. Once the applicant has both Part A and Part B completed, they must mail the full application to SunLine Transit Agency at the designated address. Incomplete applications will be returned. Every question must be answered clearly and legibly. SunLine staff will contact the health care provider who completed Part B to verify the information.