



## **GUADALUPE TRANSIT**

APPLICATION

240 East Roemer Way Santa Maria, CA 93454 (805) 922-8476 <u>(fax) 928-3846</u>

## **ADA TRANSPORTATION SERVICE**

Name:	Address:
Telephone:	City/Zip:
Language Spoken:	nglish Spa Other:
Date of Birth (Optional): Female	Age (Optional): Male
Emergency Contact Name:	Relationship:
Daytime Phone:	Evening Phone:
for ADA transportation se	r disability or condition that you feel makes you eligible ervice? Please check ALL that apply.
Cardiovascular Impairmer	nt L Developmental Disability
Difficulty Walking	Hearing Disability
Wheelchair User	Mental / Cognitive Disability
Muscular-Skeletal Disabil	ty Neurological Disability
<b>Respiratory Impairment</b>	Seizure Disorder
Visual Disability	Other: Please Specify Below
2) Has your disability been d	locumented by a medical professional or doctor?
Yes, if Yes, please stat	e the doctor's diagnosis if known.
3) Since when have you had	this disability or condition?
4) Is this disability or condit	tion temporary? 🛛 Yes 🗌 No
fixed route (Guadalupe Fl	disability/condition limits your ability to use the regular yer or Shuttle) system. <u>IF available, please attach a</u> rom a medical professional or doctor.

- 6) Are you able to independently get to and from a regular fixed route bus stop? Yes No, Please explain:
- 7) Once ON a fixed route bus, are you able to complete your trip on the fixed route?



Yes

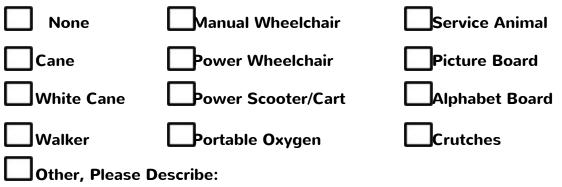
No, Please explain:

8) Are you physically able to get ON and OFF a fixed route bus?

Yes

No, Please explain:

9) Which of the mobility aids/equipment do you use to help you while being transported?



- 10) What is the approximate combined weight of you and your wheelchair?
- 11). How far can you continuously walk or move your wheelchair?(Example: "½ mile", "2 blocks", "15 minutes")
- 12). Do you require an aide or attendant in order to ride the fixed route bus?

Yes, and if so, has the aide/attendant been prescribed by your medical professional?	No
No	