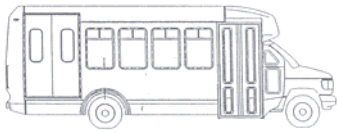


**CITY OF SANTA MARIA  
SANTA MARIA AREA TRANSIT**



SMAT USE ONLY  
\_\_\_\_New \_\_\_\_Renewal  
Date Approved \_\_\_\_\_  
Card # \_\_\_\_\_  
Date Issued \_\_\_\_\_  
Expiration Date \_\_\_\_\_

**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\* \_\_\_\_Español \_\_\_\_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.)

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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.

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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 \_\_\_\_\_