

Santa Ynez Valley Transit Dial-A-Ride Application Form

Please send application form with Photocopy of state issued ID to:

Attn: ADA Coordinator
City of Solvang
PO Box 107
Solvang, California 93464

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. Yes No
TTY/TTD (Hearing Impaired)

Please check all that apply when traveling:

- Restricted to wheelchair
If restricted to a wheelchair, is it motorized?
 Yes
 No
- Use of walking cane 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 Tape
- Braille
- TTY/TTD

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: ____/____/____