MIDDLETOWN AREA TRANSIT
MAT

Middletown Transit District
340 Main Street
Middletown, CT 06457
Phone (860) 346-0212
Fax (860) 347-8314

DIAL-A-RIDE APPLICATION

FOR PERSONS WITH DISABILITIES

Thank you for your interest in MAT shared-ride Dial-A-Ride, curb-to-curb services for persons with disabilities under the age of 60 traveling ¾ of a mile beyond the fixed route in the towns of Middletown, Portland, East Hampton, Durham and Middlefield. Registered passengers can call in advance to schedule shared ride, curb-to-curb transportation on wheelchair accessible vehicles.

QUALIFICATION:

MAT shared-ride Dial-A-Ride curb-to-curb service is available for persons age 60 or older or with a disability that limits mobility

FARE:

$3.50 One-Way

Please have exact cash, drivers cannot make change.

AVAILABILITY:

Schedule priority is given to those who make reservations first and as availability allows.

RESERVATIONS:

Trips may be scheduled up to one week in advance. Calls are accepted between the hours of 8:00 a.m. until 4:30 p.m., Monday through Friday. For reservations, please call 860-346-0212.

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Persons with mobility related disabilities or impairments regardless of age may qualify for MAT shared-ride Dial-A-Ride (curb-to-curb) services. MAT requires that you send the REQUEST FOR PROFESSIONAL VERIFICATION form (attached at end of this application) to a professional such as a doctor or case worker familiar with your disability for verification.

NAME: _____

ADDRESS: _____

APT#: _____ CITY: _____ ZIP CODE: _____

MAILING ADDRESS (If different from above): _____

APT#: _____ CITY: _____ ZIP CODE: _____

DAYTIME PHONE: _____ TDD/TTY: _____

EVENING PHONE: _____ CELL PHONE: _____

BIRTH DATE: _____ ☐ MALE ☐ FEMALE

PRIMARY LANGUAGE SPOKEN: _____

EMERGENCY CONTACT PERSON: _____

DAYTIME PHONE: _____ RELATIONSHIP: _____

EVENING PHONE: _____ CELL PHONE: _____

Do you need information given to you in a different way? _____ Yes _____ No

Check all that apply: _____ Large Print _____ Audio Tape _____ Interpreter
_____ Braille

CONDITIONS OR DISABILITIES

Have you ever used dial-a-ride or paratransit bus service? ____Yes ___No

If yes, please describe _____

_____

_____

Please list the condition(s) or disability(ies) that impact(s) your ability to travel: _____

_____

_____

How does your condition(s) affect your ability to travel? _____

_____

Is this condition/are these conditions: _____ Permanent _____ Temporary

If your impairment is temporary, please estimate how long you anticipate it will last: _____

_____

INDICATE IF YOU USE ANY OF THE FOLLOWING:

☐ WHEELCHAIR ☐ WALKER ☐ CANE ☐ SCOOTER ☐ SERVICE ANIMAL

Will you be traveling with a personal care attendant? ____ Yes ____No

On the following page, you will find a Professional Verification form. Please provide this form to a medical professional who can verify your disability. This must be completed before submitting your application.

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REQUEST FOR PROFESSIONAL VERIFICATION

_____ has indicated that you can provide information regarding his/her disability and its impact on his/her needs to use our shared ride, curb-to-curb Dial-A-Ride services for person under the age of 60 traveling ¾ mile beyond the fixed route in the towns of Middletown, Portland, East Hampton, Durham and Middlefield. The information you provide will allow us to evaluate the request and to provide service for specific trip requests. All information will be kept confidential.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What is the applicant's medical diagnosis? _____

What conditions should the applicant avoid? _____

What areas of daily living does this person need assistance with _____

_____

Do any medications that the applicant is taking; interfere with his/her ability to take a regular public bus? YES NO If yes, please describe _____

_____

Can the applicant walk a distance of 2 city blocks or up a slight incline?	Yes	No
Can the applicant wait 10 minutes for a public bus?	Yes	No
Can the applicant cross the street without assistance?	Yes	No
Can the applicant ask for, understand, and follow directions?	Yes	No
Navigate the city bus system?	Yes	No

_____	_____	_____
Name of Health Care Professional	Professional Designation (MD., R.N. etc.)	Date
	_____	
_____	_____	_____
Signature of Health Care Professional	Address	Phone

The application will not be considered complete until receipt of your verification. In order to process the application on time, please reply within **14 days. Do not fax verification back to the office**, due to the need to maintain the applicant's confidentiality. If you have any questions, please call Middletown Area Transit at 860 346-0212. Thank you in advance for your cooperation.

Please return verification to: ADA-app@mtdct.org

AUTHORIZATION TO OBTAIN
PHYSICIAN OR OTHER PROFESSIONAL VERIFICATION

After the interview, the local ADA paratransit provider may need to contact a physician or a professional familiar with your disability. Please provide the following information for a physician or professional who is able to provide the needed information that would help determine eligibility for ADA paratransit service provider. You do not need to have the professional sign this form. Please return this form with your completed application.

Physician Health Care Professional	Health Care Professional	Rehabilitation Professional
Professional's Name:		
Agency:		
Office Address:		
City:	State:	Zip:
Phone:	Office Fax:	
Applicant's Name:		Date of Birth:
Signature of applicant or guardian:		
Applicant agrees to share the application information with other service providers with the State of Connecticut?		
YES	NO	