Camel Express Transit Services

American Disability Act and Senior Transit Eligibility

Certification Application

This form will be used to determine your eligibility for reduced fare services with Camel Express provided by Western Arizona Council of Governments Area Agency on Aging. These services are fully accessible to individuals aged 60 or over, or any age with disabilities.

To better serve you please complete the entire form and answer questions as completely as possible and sign the application.

To qualify for the ADA reduced rate, a physician must verify the qualifying disability, prognosis, and date of occurrence. Verification can be obtained from your physician or an agency having the physician statement on file.

The information must be submitted with the application and can be provided on your physician's letterhead attached to the application. All information is confidential and will only be used to determine eligibility.

Upon receipt of a completed application staff will send your paperwork to Western Arizona Council of Governments to determine eligibility for reduced fare services. The Town of Quartzsite's current contract with WACOG provides up to 10 free rides per person, per month. Rides may be in or out of town but must be used to go to medical appointments, pharmacies, grocery stores, or senior nutrition programs.

Recertification may be required after a 3-year period depending on WACOG contract requirements.

WACOG
Western Arizona
Council of Governments

Applicant Information

Please Print Clearly

Last Name_____ First Name_____

Street Address_____ P.O. Box #_____

Apt or RV Park Name_____ Apt or space #_____

City_____ State_____ Zip code_____

Sex ___F ___M Age _____ DOB _____ Mobility Aid ___Y ___N

Disabled ___Y ___N AHCCCS ___Y ___N Caregiver ___Y ___N Service Animal ___Y ___N

Ethnic Background Please circle one-

Asian/Pacific, African American, Hispanic, Native American, Caucasian, Other

Low Income ___Y ___N Frail ___Y ___N Portable Oxygen ___Y ___N

Applicant's Phone Number_____

Emergency Contact Information_____

Name and phone number

Check one

_____Senior age 60 or older

Include a copy of a valid ID card or Birth Certificate. Providing proof of income such as a Social Security Award Letter or a bank statement will determine eligibility for free bus tickets through our WACOG Area Agency on Aging Partnership.

_____ADA Eligible under the American Disabilities Act of 1990

Individuals must meet one or more of the following criteria in order to be certified as ADA eligible. Check the appropriate selections which best describes the applicant's condition.

___ Cardiovascular Impairment

___ Developmental Disability

___ Difficulty Walking/Hearing

___ Mental/Cognitive Disability

___ Visual Disability

___ Muscular-Skeletal

___ Neurological Disability

___ Respiratory Impairment

___ Seizure Disorder

___ Have you ever had a seizure If so, are they controlled with medication ___Yes ___No

Do you require an attendant to use the transit service? If yes, the aide or attendant must always accompany you when using the service. ___Yes ___No

Name of attendant_____

Signature_____ Date_____

Once you have completed this form for senior eligibility, please return it to:

Camel Express Transit Agency

465 North Plymouth Avenue/PO box 2812

Quartzsite, Arizona 85346

To establish verification of disability, please make sure your physician has completed the enclosed forms and return them to the above address.

Camel Express
Discounted Services
American Disabilities Act (ADA) of 1990

Physician Verification of Disability Form
(Deliver or mail to your doctor)

Please complete, sign, and mail this Verification of Disability form as soon as possible. Your patient is being considered for eligibility for Discounted Services with **Camel Express Transit Agency**.

Mail to: P.O. Box 2812, Quartzsite, AZ 85346. Fax: 928-927-4400. Email: jcollier@quartzsiteaz.org

Patient Name:_____ DOB:_____
The patient named above _____ is currently being treated or _____ was formerly treated by me.
Type of condition/disease:_____ Date of onset:_____
Prognosis:_____
Does this patient require a mobility travel aid? _____ Yes _____ No

Disability Status

_____Patient will be temporarily disabled for _____ months.
_____Patient is considered permanently disabled.

FOR VISUAL IMPAIRMENT

Right eye:_____ Left Eye:_____
My signature** below certifies that the above information is accurate

_____
Physician's signature and credentials (M.D., O.D.) Print physician's name and credentials

License Number:_____ State:_____
Phone #:_____ Date:_____

Please include Physician's stamp here: