

**Dial-A-Ride Paratransit Application**  
**Rapid Transit System**  
**Public Works Department**  
**City of Rapid City**



**SECTION 1:**

**Applicant Portion Information | Page 1-2 | To be provided to the applicant**

**Directions:** Read the following information before moving forward with the application. This information explains transportation requirements of the Americans with Disabilities Act (ADA) and identifies the features of Dial-A-Ride. Dial-A-Ride is a ride-share service provided to certified individuals who are unable to use lift-equipped, accessible, fixed-route bus service provided by RapidRide. The purpose of Dial-A-Ride is to provide equal and comparable transportation access.

**APPLICATION PROCESS:**

1. Applicants must complete their portion of the application form (Sections 1-6, Pages 1-12). Incomplete applications will not be processed. Applications will be considered incomplete if they have missing or improperly completed questions, pages, or sections. Applicants are welcome to enlist the assistance of a caretaker, family member or friend when completing the application.
2. Applicants are responsible for forwarding the Medical Provider Portion (Sections 7-9, Pages 13-16) to a health care provider, rehabilitation professional or medical staff familiar with their disability and functional ability to use lift-equipped, accessible, fixed-route bus service. Dial-A-Ride will not submit these pages to a provider on an applicant's behalf.
3. Applications can be printed, completed by hand, and signed before submission.
4. Applicants must ensure all portions of the application are submitted to the Rapid Transit System. Processing can only begin once RTS has received all the necessary documentation.
5. An applicant's eligibility for Dial-A-Ride services will be determined within 21 days. Incomplete applications cannot be held pending for extended periods of time.
6. Applications can be submitted by postal mail, by email, or in person. Applicants are encouraged to keep pages 1-2 of the application for their records.

**FREQUENTLY ASKED QUESTIONS:**

**What is ADA Paratransit?**

- The Americans with Disabilities Act of 1990 (ADA) recognizes that some individuals are unable to use a fixed-route bus service even if the service is fully accessible. The ADA requires that transit agencies providing fixed-route bus services must also provide complementary ADA Paratransit services. This paratransit service is for those persons whose disability prevents them from using a fixed-route bus service for some or all their transportation needs. This does not include disabilities that make use of a fixed-route transit service difficult or inconvenient. According to the law, ADA Paratransit is to "complement" the fixed-route bus service by providing service that is comparable in terms of service area, days/hours of operation, and several other factors. The specific criteria for determining who is eligible for ADA Paratransit are defined by ADA law.

**What is Dial-A-Ride?**

- Dial-A-Ride (DAR) is the ADA Paratransit service established by the Rapid Transit System (RTS) as the complimentary, fixed-route service, RapidRide (RR).

**Is Dial-A-Ride the only transportation offered for those with disabilities?**

- No. The fixed-route RapidRide system is accessible to those with disabilities and/or those using mobility devices.

**Where do the eligibility requirements come from?**

- The specific criteria for determining who is eligible for ADA Paratransit are defined by ADA law.

**Are there different types of eligibility and approvals?**

- Riders may be approved permanently or temporarily, as well as conditionally or unconditionally. Upon approval of services riders are informed of their status and provided with any additional guidance necessary. Riders who meet the criteria for service, but do not reside in Rapid City, may be approved as a visiting rider for 21 days. These days are calculated over a period of 365 days. Visiting riders will need to provide documentation and are encouraged to contact the RTS as far in advance as possible

**Is Dial-A-Ride right for me?**

- Only riders who meet the criteria specified by the ADA are able to use Dial-A-Ride services. Eligibility is based on necessity, not preference. Finances, driving ability, age and comfort are just some examples of situations, while difficult, are not taken into consideration during the application process. As a complimentary or “sister” service, DAR follows many of the same restrictions and is comparable in convenience in areas including wait times, length of trips, etc. to the RapidRide, the fixed-route service.

**Is Dial-A-Ride free?**

- Dial-A-Ride is not a free service. The cost for a ride varies from \$3.00 to \$3.50 each trip. Dial-A-Ride fares cannot be billed to insurance and a “No Fare No Ride” policy is enforced.

**Is Dial-A-Ride a taxi service?**

- No. Dial-A-Ride is an appointment based, ride-share service whereas all passengers are picked-up and dropped off in an order that is most efficient. Passengers will ride on the bus with others which impacts travel, arrival and departure times by as much as one hour. In addition, DAR drivers do not offer taxi-like services such as loading/unloading a rider’s belongings.

**Does Dial-A-Ride provide last-minute, emergency or medical transportation services?**

- Dial-A-Ride drivers are not medical providers and those having medical emergencies are encouraged to call 911 for emergency medical services. All ride requests must be made no later than the day prior by 3:30pm as DAR does not offer same-day ride requests even for urgent needs.

**Where can the Dial-A-Ride buses go?**

- Dial-A-Ride buses will not transport outside of City of Rapid City limits. All ride requests require a physical street address. Some locations may be inaccessible to a DAR bus for safety reasons, however every reasonable attempt will be made to transport riders as close to their location as possible.

To submit your application, acquire documentation in an alternative format, request an accommodation or gain assistance, please contact:

**Erin Kistler, Interim  
Operations Coordinator**

**605-394-6631 extension 6  
erin.kistler@rcgov.org**

**Milo Barber Transportation Center  
333 6<sup>th</sup> Street Rapid City, SD 57701**

*A more detailed handbook that contains in-depth Dial-A-Ride information is available on our website or one can be requested in person at the Milo Barber Bus Depot, by phone or email.*



If assistance was provided in completing this form, please indicate by whom:

Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Should this person be contacted directly if additional information is required?

Yes      No

**Emergency Contact**

Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

### SECTION 3

#### Applicant Eligibility Information | Pages 5-6 | To be completed by applicant and/or caretaker

**Directions:** Answer all of the following questions in detail. Your specific answers to the questions will help determine your eligibility. Do not skip any pages or questions. Incomplete applications will not be processed.

For some questions indicate your answer by circling "Yes" or "No". As indicated, some answers must be accompanied by an explanation. Please read each question carefully. If necessary, use an additional piece of paper in order to answer all questions thoroughly.

1. Are you disabled?      Yes              No

a. **Note:** *This question is not inquiring about services you may/may not be receiving, such as disability benefits, enrollment in special education programs, accessible parking placard, etc.*

2. What is your specific disability and/or medical diagnosis that prevents you from using the fixed-route bus service? Please describe all disabilities that affect your travel.

a. **Note:** *This question is not inquiring about your symptoms, abilities, mobility devices, etc.*

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3. How does/will your disability specifically prevent you from boarding/exiting, riding, navigating the routes, going to/from stops, or otherwise independently using the fixed-route service? Please explain completely.

a. **Note:** *This question is not inquiring about what your disability is, but rather how it affects your travel abilities.*

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4. Is your disability? (circle)              Permanent              Temporary              Conditional

If temporary, what is the anticipated end date? Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

If conditional, what conditions would affect your use of the bus system?

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**5. How do you currently travel to and from your most frequent destinations?**

**Circle all that apply.**

RapidRide/Fixed Route

Taxi/Lyft/Similar Service

Drive Myself

Someone Drives Me

Other: \_\_\_\_\_

**6. Have you ever used any fixed-route bus system?**

Yes, in Rapid City

Yes, somewhere else

No

If Yes, please explain your experiences: \_\_\_\_\_

\_\_\_\_\_

**7. Have you ever applied or been approved for Dial-A-Ride?**

Yes

No

**8. Are you ADA certified in another City?**

Yes

No

If yes, which City and State: \_\_\_\_\_

## SECTION 4:

### Applicant Travel Ability | Pages 7-9 | To be completed by applicant and/or caretaker

**Directions:** Answer all of the following questions in detail. Your specific answers to the questions will help determine your eligibility. Do not skip any pages or questions. Incomplete applications will not be processed.

For some questions indicate your answer by circling "Yes" or "No". For others you may be asked to put a check mark next to the task you CAN perform, while others questions are open-ended. As indicated, some answers must be accompanied by an explanation. Please read each question carefully. If necessary, use an additional piece of paper in order to answer all questions thoroughly.

#### 1. I am able to:

- Recognize a destination or landmark to know where I am
- Ask for help when needed
- Read/hear, understand and follow directions
- Maintain my personal safety when unaccompanied

#### 2. I am or would be able to identify the correct fixed-route bus and bus stop.

Yes            No

#### If not, I could identify the correct fixed-route bus and bus stop if: (check all that apply)

- I had Travel Training
- I knew where the stops were located
- I knew what the buses looked like and/or what the routes were named
- Other: \_\_\_\_\_
- None of the above or could not under any circumstance

#### 3. I am or would be able to travel, with or without a mobility device, to and from the nearest fixed-route bus stop.

Yes            No

- I had Travel Training
- I understood the routes
- There are sidewalks, level ground and curb cut
- There is no extreme weather
- It is day time and/or well lit
- I had someone to accompany me
- Other: \_\_\_\_\_
- None of the above or could not under any circumstance

**4. I am or would be able to wait up to 15 minutes at a bus stop.**

Yes                      No

**If not, I am or would be able to wait up to 15 minutes at a bus stop if: (check all that apply)**

\_\_\_\_\_ There is a bench, shelter or other seating opportunity

\_\_\_\_\_ I had someone to accompany me

\_\_\_\_\_ There is no extreme weather

\_\_\_\_\_ It is day time and/or well lit

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ None of the above or could not under any circumstance

**5. I do or will board and exit the bus independently (without physical assistance) by using the:**

Bus Lift or Ramp

Climbing a 12-inch Step with Rails

I don't know

**6. What is the approximate distance you can travel with or without a mobility device? Use any unit of measurement that is easiest for you (example: 1 mile, 2 blocks, 20 feet, etc.):**

\_\_\_\_\_

**7. Do you require assistance in order to get to and from the bus if it is parked at or near the front entrance?**

**a. Note:** *Drivers do not go into homes or other locations, provide physical support for ambulation, or carry personal belongings.*

Yes                      No

**If yes, what type of assistance do you require?**

Pushing of a manual wheelchair

Guidance for a visual impairment

Other: \_\_\_\_\_

**8. Which mobility devices or equipment would you primarily use while riding the bus?**

Cane

Walker

Crutches

Manual Wheelchair

Electric Wheelchair

3-Wheel Scooter

Portable Oxygen

Other: \_\_\_\_\_

If you use a wheelchair or a scooter, what is the approximate **combined** weight of the occupant and wheelchair/scooter? \_\_\_\_\_ *(answer is required, reasonable estimate is acceptable)*



**9. My use of mobility devices or equipment may change day-to-day.**

Yes      No

**If Yes, please explain:** \_\_\_\_\_

**10. I require a personal care attendant (PCA) to travel with me for some or all of my rides?**

Yes      No

**11. I require a service animal to travel with me for some or all of my rides?**

Yes      No

**12. I may have a pet, emotional support or comfort animal ride with me for some or all of my rides.**

Yes      No

**SECTION 5:**

**Applicant Acknowledgement | Page 10 | To be completed by applicant and/or caretaker**

**Directions:** Review the following information. Do not skip any pages or questions. Incomplete applications will not be processed. Applicants must print, sign and date if possible. If another person is submitting this documentation on the applicant’s behalf, their information is required.

1. I certify that the information in this application is true and correct.
2. I understand that falsification of the information may result in denial of service.
3. I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform the services.
4. I understand that it may be necessary for the Rapid Transit System to contact me, my caretaker and/or my medical provider to assist in determination of eligibility.
5. I understand Dial-A-Ride is only available to those with a disability that prevents the use of the fixed route.
6. I understand that the fixed-route, RapidRide service is accessible and free travel training is available to me.
7. I understand Dial-A-Ride is not a free service and trip fares cannot be billed to insurance.
8. I understand that the occasional ability to use RapidRide will not automatically disqualify me from Dial-A-Ride services.
9. I understand that Dial-A-Ride is a ride-sharing, public transportation service and is not a taxi, emergency or medical only transportation.
10. I understand that submitting an incomplete application may result in a denial.
11. I understand that it is my responsibility to forward the Medical Provider Portion.

\_\_\_\_\_  
Applicant Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

**Person submitting application if not applicant**

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

**SECTION 6:**

**Professional Authorization | Page 11 | To be completed by applicant and/or caretaker**

**Directions:** Record your medical provider’s information below. You may choose any provider that is familiar with your disability or health related condition and your functional ability to use the lift-equipped, accessible, fixed-route service. The provider listed on this page must be the same provider that completes the Medical Provider Portion. Applicants must print, sign and date if possible. If another person is submitting this documentation on the applicant’s behalf, their information is required. Do not skip any pages or questions. Incomplete applications cannot be processed.

**Professional Authorization**

\_\_\_\_\_  
Medical Provider’s Name Clinic/Office/Hospital/Agency

\_\_\_\_\_  
Medical Provider’s Address City State Zip

\_\_\_\_\_  
Medical Provider’s Phone

I hereby authorize the above named professional to release to Rapid Transit System the necessary information about my disability in order to verify my eligibility for Paratransit services. The information released will be used solely to determine my eligibility. I realize that I have the right to receive a copy of this authorization at any time.

\_\_\_\_\_  
Applicant Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

**Person submitting application if not applicant**

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

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## SECTION 7:

### Medical Provider Portion Information | Page 13 | To be provided to the health care provider, rehabilitation professional or medical staff

#### Directions:

- Applicant – Include your name on the line below and provide Sections 7-9, Pages 13-16, to your provider of choice.
- Provider – Read the following information and reach out to RTS at the contact information below if you have any questions.

Applicant's Name: \_\_\_\_\_

The above-named applicant has identified you as a health care, rehabilitation professional and/or medical provider that is familiar with his or her disability. They are applying for paratransit services and they have given us permission to contact you for additional information if needed.

The information in this application is necessary to determine which transit services the individual is eligible to use under the regulations of the federal Americans with Disabilities Act (ADA).

Before completing the next three pages, please verify that you are familiar with the applicant's functional abilities to use transit services and are aware of the following:

- All fixed-route buses operated by Rapid Transit System have wheelchair lifts/ramps to allow boarding by individuals using mobility devices as well as other riders who find use of the steps difficult. Free travel training is available to those who are unfamiliar with the fixed routes.
- The ADA has mandated that ADA Paratransit service be available to persons whose disabilities prevent their use of lift-equipped, accessible, fixed-route bus services. Aspects such as preference, comfort, difficulty, loss of driver's license, financial status or inexperience with the fixed-route are not taken into consideration.
- **Disability alone does not automatically qualify an individual for ADA Paratransit service.**

We are asking you, as a professional, to give us accurate information regarding the functional abilities of the individual named above so that we can determine whether the individual is eligible for Rapid Transit System's ADA Paratransit service.

Please complete Section 7-8, Pages 13-16, and return the documentation promptly to our office by email, postal mail or in person. You are encouraged to keep a copy of this page and the application for your records.

**Erin Kistler,  
Interim Operations Coordinator  
Rapid Transit System  
City of Rapid City**

**Milo Barber Transportation Center  
333 6th Street  
Rapid City, SD 57701**

**Phone: 605-394-6631 extension 6  
Email: erin.kistler@rcgov.org**

**SECTION 8:**

**Medical Portion | Page 14-15 | To be completed by the health care provider, rehabilitation professional or medical staff**

**Directions:** Answer all of the following questions in detail. Your specific answers to the questions will help determine the applicant’s eligibility. Do not skip any pages or questions. Incomplete applications cannot be processed.

- 1. **Is the applicant disabled?**      Yes      No
  - a. **Note:** *This question is not inquiring about services they may/may not be receiving, such as disability benefits, enrollment in special education programs, accessible parking placard, etc.*
  
- 2. **What is their specific disability and/or medical diagnosis that prevents them from using the fixed-route bus service? Please describe all disabilities that affect their travel.**
  - a. **Note:** *This question is not inquiring about their symptoms, abilities, mobility devices, etc.*

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- 3. **How does/will their disability specifically prevent them from boarding/exiting, riding, navigating the routes, going to/from stops, or otherwise independently using the fixed-route service? Please explain completely.**
  - a. **Note:** *this question is not inquiring about what their disability is, but rather how it affects their travel abilities. The presence of a disability or use of a mobility device do not automatically qualify a person for Dial-A-Ride.*

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- 4. **Is their disability? (circle)**      Permanent      Temporary      Conditional  
If temporary, what is the anticipated end date? Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_  
If conditional, what conditions would affect their use of the bus system? \_\_\_\_\_

- 5. **The applicant is able to:**
  - \_\_\_\_\_ Recognize a destination or landmark to know where they are
  - \_\_\_\_\_ Ask for help when needed
  - \_\_\_\_\_ Read/hear, understand and follow directions
  - \_\_\_\_\_ Maintain their personal safety when unaccompanied

- 6. **The applicant is able to:**
  - \_\_\_\_\_ Able to identify the correct fixed-route bus and bus stop

- If not, the applicant could identify the correct fixed-route bus and bus stop if: (check all that apply)**
- \_\_\_\_\_ They had Travel Training
  - \_\_\_\_\_ They knew where the stops were located
  - \_\_\_\_\_ They knew what the buses looked like and/or what the routes were named
  - \_\_\_\_\_ Other: \_\_\_\_\_
  - \_\_\_\_\_ None of the above or could not under any circumstance

**7. The applicant is able to:**

\_\_\_\_\_ Travel, with or without a mobility device, to and from the nearest fixed-route bus stop.

**If not, the applicant could travel, with or without a mobility device, to and from the nearest fixed-route bus stop if: (check all that apply)**

- \_\_\_\_\_ They had Travel Training
- \_\_\_\_\_ They understood the routes
- \_\_\_\_\_ There are sidewalks, level ground and curb cut
- \_\_\_\_\_ There is no extreme weather
- \_\_\_\_\_ It is day time and/or well lit
- \_\_\_\_\_ They had someone to accompany me
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ None of the above or could not under any circumstance

**8. The applicant is able to:**

\_\_\_\_\_ Wait up to 20 minutes at a bus stop.

**If not, the applicant would be able to wait up to 20 minutes at a bus stop if: (check all that apply)**

- \_\_\_\_\_ There is a bench, shelter or other seating opportunity
- \_\_\_\_\_ They had someone to accompany me
- \_\_\_\_\_ There is no extreme weather
- \_\_\_\_\_ It is day time and/or well lit
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_ None of the above or could not under any circumstance

**9. Is the applicant able to independently climb a 12-inch step with rails in order to board and exit a bus or do they require a lift or ramp?**

Lift/Ramp      Steps

**10. What is the approximate distance the applicant can travel, with or without a mobility device? Use any unit of measurement (example: 1 mile, 2 blocks, 20 feet, etc.):**

\_\_\_\_\_

**11. Does the applicant require assistance in order to get to and from the bus if it is parked at or near the front entrance?**

a. **Note:** *Drivers do not go into homes or other locations, provide physical support for ambulation, or carry personal belongings.*

Yes      No

**If yes, what type of assistance do they require?**

Pushing of a manual wheelchair      Guidance for a visual impairment  
Other: \_\_\_\_\_

**12. Does the applicant require a personal care attendant (PCA) to travel with them for some or all of their rides?**

Yes      No

**SECTION 9:**

**Medical Portion Acknowledgement | Page 16 | To be completed by the health care provider, rehabilitation professional or medical staff**

**Directions:** Review the following information. Include all identifying and contact information, print sign and date.

**Medical Provider's Information:**

\_\_\_\_\_  
Medical Provider's Name Clinic/Office/Hospital/Agency

\_\_\_\_\_  
Medical Provider's Address City State Zip

\_\_\_\_\_  
Medical Provider's Phone

**Professional Licensure:**

- |   |  |
|---|--|
| <input type="checkbox"/> Physician                      | <input type="checkbox"/> Nurse (NP, APRN, RN, LPN or other: _____) |
| <input type="checkbox"/> Physician Assistant            | <input type="checkbox"/> Audiologist                               |
| <input type="checkbox"/> Physical Therapist             | <input type="checkbox"/> Psychologist or Psychiatrist              |
| <input type="checkbox"/> Occupational Therapist         | <input type="checkbox"/> Other Mental Health Professional: _____   |
| <input type="checkbox"/> Speech Language Pathologist    | <input type="checkbox"/> Chiropractor                              |
| <input type="checkbox"/> Podiatrist                     | <input type="checkbox"/> Other Rehabilitation Specialist: _____    |
| <input type="checkbox"/> Optometrist or Ophthalmologist | <input type="checkbox"/> Clinical Social Worker                    |
| <input type="checkbox"/> Other: _____                   |  |

By signing below, I certify that I have supplied the information provided on this form and it is true and correct. I understand that falsification of the information may result in denial of service for the applicant.

\_\_\_\_\_  
Medical Provider Name (please print) Date

\_\_\_\_\_  
Medical Provider Signature