Jefferson Township Dial-A-Ride ~ Registration Form

The Dial-A-Ride system is Jefferson Township's ***Curb to Curb*** paratransit service for Jefferson Township senior citizen residents 62 years of age and/or Jefferson Township resident(s) with permanent disabilities. After initial assessment, Dial-A-Ride may require the client to be assisted by an aid. Part I filled out by all **Clients and must provide photocopy of age verification and Jefferson Township Residence**. Part II of this registration form only needs to be submitted if the consumer is under 62 and/or is requesting transportation for physical therapy. If the consumer is under 62 and has a disability as per ADA regulations, a letter acknowledging your disability status (from the Social Security Administration or other Governmental Agency) **MUST** also be submitted, in addition to the above. Should you have any questions, please contact the Dial-A-Ride office at 973-208-6123. Completed forms should be forwarded to:

Township of Jefferson Attn: Dial-A-Ride Office
1033 Weldon Road
Lake Hopatcong, NJ 07849 (Or fax to: 973-697-3603 or 973-697-4033)

Part I (to be completed by ALL applicants):

Name: _____

Address: _____

_____

Telephone: (_____) _____ - _____ Cell: (____) _____- _____ Date of Birth: _____

Emergency Contact (name and **cell phone** number)

_____

Ambulatory (__) Semi-Ambulatory (__) (Walker/cane) Uses Assistive Device (__) (wheelchair or scooter)

Covid19 Vaccinated? Yes (__) No (__)

Do you receive Medicaid? Yes (__) No (__) Received & Read: Rules & Regulations Yes (__) No (__)

Applicant's Signature: _____ Date: _____

Part II (to be certified by healthcare provider): only needs to be filled out if you are disabled and under 62 or if you are requesting physical therapy transportation and are over 62

Physical Therapy Start Date: _____ Physical Therapy End Date: _____
Or provide a copy of your physical therapy prescription.
* (Physical Therapy - We have the right to review and reassess the request after a 3-month time period.)

Physician's Name: _____

Address: _____

Telephone: (_____) _____ - _____
I certify that the above individual meets the ADA regulations as follows: the person (1) has a physical or mental impairment that substantially limits a major life activity, (2) has a record of such an impairment, or (3) is regarded as having such an impairment.

Physician's Signature: _____ Date: _____
Physician's License #: _____

** Completion of this form does not guarantee transportation. Each request is reviewed on a case-by-case basis and subject to availability.