Attached is an application to request certification for ADA paratransit services eligibility. When the application is completed please forward to:

Wichita Transit
777 E. Waterman
Wichita, Kansas 67202
FAX: 316-858-7598
OR EMAIL: paratransit@wichita.gov

Wichita Transit's paratransit service is a shared-ride, door-to-door service for people whose disabilities prevent them from using fixed-route bus service. A "reasonable accommodation" request will be reviewed, individually, for persons needing assistance from the entry of a residence to the vehicle and/or vice versa. Wichita Transit employees are not authorized and will not enter any residence. Wichita Transit provides paratransit van service for people who are unable to use available fixed route services for some or all of their trips.

When a completed application is received, information will be reviewed for eligibility by a representative from the Wichita Transit Paratransit Division in accordance with the criteria outlined in 49 CFR part 37. If eligibility has not been determined within twenty-one (21) days of receipt, applicants will be "presumed eligible" until a full application review can be completed. Once the application review is complete, applicants will be notified by letter from the Paratransit Division as to the level of eligibility and length of certification.

As part of the application review process, applicants may be asked to attend an in-person interview and/or to undergo an evaluation to help determine when, and under what circumstances, they can use fixed route buses and when paratransit shared-ride service is required. There is no charge for this evaluation and transportation to and from the evaluation and/or interview will be provided at no charge. The functional physical evaluation consists of a simulated bus travel experience, including boarding, maneuvering a curb and a curb cut, and crossing the street. Skills evaluated include balance, strength, coordination and range of motion. The cognitive functional assessment consists of certain standardized tests designed to measure skills such as memory, attention span and route-finding ability. Functional vision and respiratory considerations may also be reviewed. Additionally, variables in the environment are considered.

If an application for eligibility is denied, an appeal of the decision can be made to the City's ADA Coordinator. The request for appeal review must be submitted within 60 days of notification the eligibility denial. The period for review of all appeal requests will be limited to sixty (60) days. If after 30 days the appeal has not been decided, applicants will be presumed eligible until a final determination is reached. The individual making the appeal has the right to be heard in person and to have the necessary support, such as a sign language interpreter.

All requests must be submitted to the Paratransit Division. Appeals can be submitted by email paratransit@wichita.gov, by phone (316) 352-4828, by fax (316-858-7598), or in writing (see address below). When requesting an appeal, please provide name, address, telephone number, and a brief explanation of the basis for your appeal. Applicants are welcome to appear in person to present an appeal. Applicants planning to appeal in person should request any special requirements, such as a sign language interpreter, in advance so Wichita Transit can make the appropriate arrangements when scheduling appointments. Transportation to and from the appeal will be provided at no charge. Written appeals should be addressed to:

Paratransit Division
777 E. Waterman
Wichita, Kansas 67202
FAX: 316-858-7598
OR EMAIL: paratransit@wichita.gov

If you have any questions, would like assistance completing the application, or would like to request a hearing or appeal, please feel free to contact Wichita Transit at (316) 352-4828.

Wichita Transit

APPLICATION FOR CERTIFICATION OF ADA PARATRANSIT ELIGIBILITY

The information obtained in this certification process will only be used by Wichita Transit to determine an applicant's eligibility for paratransit service. Information will only be shared with other transit providers to help provide travel if needed. The information will not be provided to any other person or agency.

APPLICANT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Ph: _____ Work/Cell Ph: _____

Birth Date: _____ Gender: _____

In the event of an emergency, please provide contact information below:

Name: _____ Phone: _____

Special Instructions, if any: _____

_____

_____

INTERNAL USE ONLY			
Date Received:			
Type of Application:	☐ New	☐ Renewal	
Determination:	☐ Standard Eligibility	☐ Temporary Eligibility	☐ Not Eligible
Type of Eligibility:	☐ Unconditional	☐ Conditional (please list)	
_____			
_____			
Date of Certification:			
Client ID Number:			
Expiration Date:			
Notes/Comments:			

PLEASE RETURN COMPLETED APPLICATION TO:
WICHITA TRANSIT PARATRANSIT DIVISION
777 E. Waterman ◆ Wichita, KS 67202
(316) 352-4828 -office ◆ paratransit@wichita.gov

SECTION I - ELIGIBILITY INFORMATION (TO BE COMPLETED BY THE APPLICANT OR THEIR DESIGNEE)

Please answer the questions below regarding general eligibility:

A. Briefly describe your disability or condition. Explain how this disability or condition prevents you from using the fixed route bus system.

Is this condition temporary? ☐ Yes ☐ No If yes, expected duration until (date)?
_____/_____/_____

B. Are there other effects of the disability which may be a factor in your ability to use the shared-ride paratransit service?

C. Are you legally blind? ☐ Yes ☐ No

(Note: Legally blind is defined as the visual acuity in your best eye with best correction is no better than 20/200 on the Snellen acuity scale, or the vision field of the best eye is constricted to less than 20 degrees.)

If you have a visual impairment, please complete the information below:

Visual Acuity: _____ Right Eye: _____ Left Eye: _____ Field of Vision: _____

D. Do you require a Personal Care Attendant (PCA) when traveling?

☐ Always ☐ Never ☐ Sometimes (please explain those times when you need a PCA below)

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SECTION II – APPLICANT MOBILITY (TO BE COMPLETED BY THE APPLICANT OR DESIGNEE)

Please answer the questions below regarding your mobility:

A. Do you require the use of a mobility device? ☐ Yes ☐ No ☐ Sometimes

If "Yes" or "Sometimes", please select the device(s) used most frequently:

☐ Orthopedic Cane ☐ Long, white cane for the blind ☐ Walker ☐ Crutches

☐ Manual Wheelchair ☐ Powered Wheelchair ☐ Powered Scooter

**If you selected any of the wheeled devices above, please indicate the physical dimensions:

Width: _____inches Height: _____inches Length: _____inches

Combined weight of passenger and device: _____lbs.

(Note: vehicles lifts can accommodate a maximum combined weight of 800lbs and mobility device dimensions of 32" wide, 48" long, and 56" high.)

☐ Portable Oxygen ☐ Augmentative Communications Devices (picture board, alphabet board, etc.)

☐ Service Dog ☐ Guide Dog ☐ Hearing Assistance Dog ☐ Professional Therapy Dog

☐ Other Service Animal: _____

If "Service Animal" was selected, please indicate the breed and task the animal will perform:

_____

_____

B. Do you require use of a mobility device for a <u>temporary</u> condition? ☐ Yes ☐ No

If yes, expected duration until (date) _____/_____/_____

C. Are you able to grasp railings, handles, and fare payment items (money, cards, etc.)? ☐ Yes ☐ No

D. Are you able to keep balance while seated on a moving vehicle? ☐ Yes ☐ No

E. Please answer the following general mobility questions:

Can you travel 200 feet without the assistance of another person? ☐ Yes ☐ No ☐ Sometimes

Can you travel 1/4-mile without the assistance of another person? ☐ Yes ☐ No ☐ Sometimes

Can you travel 3/4-mile without the assistance of another person? ☐ Yes ☐ No ☐ Sometimes

Can you wait outside for up to 15 minutes? ☐ Yes ☐ No ☐ Sometimes

Can you communicate with a driver? ☐ Yes ☐ No ☐ Sometimes

Is your ability to perform any of the tasks above impaired by conditions such as terrain, climate, or weather?

☐ Yes ☐ No ☐ Sometimes If "Yes" or "Sometimes", please explain the conditions:

_____

_____

_____

_____

Please use the space below to provide any additional information that you feel is important in helping Wichita Transit determine your eligibility:

_____

_____

_____

_____

SECTION III – CERTIFICATIONS

APPLICANT CERTIFICATION

I hereby certify that the information provided in this application is true according to the best of my knowledge and belief. I understand that false statements made herein may result in a denial of service. I understand that Wichita Transit may contact the health care professional who has completed the professional verification section of this application in order to confirm this information.

Applicant Signed_____ Date_____/_____/_____

If this application was prepared by someone other than you, please sign above and provide the information below:

Name: _____

Address_____

City_____ State_____ Zip Code_____

Phone Number_____

Relationship to Applicant_____

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THE SECTION BELOW MUST BE COMPLETED BY A HEALTHCARE PROFESSIONAL ONLY

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HEALTHCARE PROFESSIONAL CERTIFICATION
TO BE COMPLETED BY MEDICAL PROFESSIONAL ONLY

You are being asked by the applicant named in Section I of this application to provide information regarding his/her ability to use the regular fixed-route services provided by Wichita Transit. For those persons who are not able to use the regular fixed-route services, with the accommodations provided, the transit system may provide paratransit van services. The information you provide will allow us to evaluate the request and determine this individual's specific needs. Thank you for your cooperation in this matter.

Please note: All regular fixed-route and Westside Feeder service operated by Wichita Transit are currently accessible to persons with disabilities who need lift-equipped vehicles, vehicles which kneel to the curb, and/or announcement of bus stops.

In order to be eligible for the paratransit services, the individual must be **unable** to access these services due to conditions which **prevent** them from getting to or from a fixed-route bus stop, or transferring between vehicles, and/or conditions which **prevent** them from being able to get on, ride, or get off a lift-equipped vehicle. Individuals for whom performing these tasks is inconvenient or uncomfortable are **not eligible** for services, and you are asked to verify this information.

It is extremely important that you provide as much specific information as possible about the individual's **functional limitations** so that eligibility determination can be made. Incomplete, inadequate, or missing information may result in a delay or denial of service for the applicant.

Please follow these steps to verify this application:

1. Read the applicant's statements provided in Section I and II in its entirety
2. Fill out the Medical Professional Certification completely using the criteria provided
3. Return completed application to applicant within 7 days of receipt (applicant is responsible for returning application to paratransit provider).
4. Be aware that you may be contacted for further information about applicant's abilities.
5. If you have questions, contact Wichita Transit by email (paratransit@wichita.gov) or by phone at (316) 352-4828.

THIS PORTION MUST BE COMPLETED BY ONE OF THE FOLLOWING RECOGNIZED PROFESSIONS: registered nurse, physician, psychologist, nurse practitioner, physician's assistant, ophthalmologist, optometrist, certified orientation and mobility specialist, or other healthcare professional employed by a medical facility.

Applicants may be found eligible for paratransit door-to-door bus services for all trip requests (based on functional ability) or for trips in which conditions exist that **prevent** them from using the fixed route bus service. **All fixed route buses are equipped with a lift or ramp for riders who use a wheelchair or cannot climb stairs.** The information provided will enable Wichita Transit to make an appropriate determination for each trip request. All information will be kept confidential. Thank you for your assistance.

PROFESSIONAL VERIFICATION FOR

_____

(Print Patient's Name)

Required Information: (Failure to provide information may cause a delay in the application process.)

A. I have reviewed the information in Section I and II in its entirety and agree with the information provided:

☐ YES ☐ NO, please explain: _____

_____

B. Please describe the condition causing the applicant's disability: _____

_____

_____

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C. Please specify which functional limitations are associated with this condition. **PLEASE BE AS SPECIFIC AS POSSIBLE.**

☐ Mobility Impairment ☐ Visual Impairment ____ *Total* ____ *Partial*

☐ Cognitive Impairment ☐ Hearing Impairment ____ *Total* ____ *Partial*

☐ Endurance Impairment ____ *Muscular* ____ *Respiratory*

☐ Other (Please describe below)

_____

_____

If this individual has functional limitations due to a cognitive impairment, please indicate any of the following issues that are pertinent to this individual:

☐ Cannot communicate independently with individuals

☐ Cannot be left alone to wait for transportation

☐ Displays behavior that is unsafe for self or others in public

☐ Cannot recognize vehicles that she/he should board

What is the expected duration of this individual's condition?

☐ Temporary – approximate duration until _____

☐ Long term – potential for functional improvement or periods of remission over time

☐ Permanent – no expectation of functional improvement

D. Does the applicant require a Personal Care Attendant (PCA) when using public transportation?

☐ Always ☐ Never ☐ Sometimes (please explain those times when a PCA is needed below)

_____

_____

E. For any impairment checked above, please note specific precautions that applicant must follow:

How far can the applicant walk without assistance: _____ blocks

How far can the applicant travel using a mobility device: _____ blocks

How long can the applicant stand and wait outside without support or sitting: _____ minutes

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F. Please explain any other considerations for this applicant that may prevent them from using the fixed-route bus system: _____
_____
_____
_____

Medical/Healthcare Professional Contact Information (Please Print):

Hospital/Physician's Office/Agency: _____

Name _____

Title_____

Address_____

City_____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Signature below indicates that I certify that I have either assisted with or reviewed the information in this application for the above named individual.

Signed_____ Date_____/_____/_____
(Must be signed by the physician or recognized professional)

IF AVAILABLE, PLEASE STAMP THE BOX BELOW WITH YOUR CONTACT INFORMATION

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