

Application for ADA Paratransit Service

IMPORTANT INFORMATION FOR APPLICANTS

This packet includes information and forms you need to apply for paratransit (Dial-A-Ride) eligibility in the Kings County area.

As part of the requirements of the Americans with Disabilities Act (ADA), paratransit service is provided by all public transportation systems. This special type of public transportation service is limited to persons who are unable to independently use regular KART routes, some or all of the time, due to a disability or health related condition.

In order to use ADA paratransit (Dial-A-Ride) service, you must be certified as eligible. Eligibility is determined on a case-by-case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible public transportation.

Your application may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility). If you are found to be capable of using regular bus routes for all trips, without the help of another person, you will not be eligible for ADA paratransit (Dial-A-Ride) Service.

To apply for eligibility (whether new or applying for recertification) you must **fully complete** the attached application form. We will review your ability to use accessible public transportation.

Applicants and persons assisting them are encouraged to read the brochure called “Kings Area Rural Transit ADA Policy” before completing the attached form. Please call 582-3211 #2711 or #2717 if you need a brochure. It provides more details about ADA paratransit and the conditions for eligibility.

Your application will be processed within 21 days after it has been received. The application must be properly completed, and you must attach the Medical Provider Statement of Applicant’s Disability.

You will receive notice of your eligibility determination by mail. If you are certified as eligible, you will be eligible to travel on the ADA paratransit (Dial-A-Ride) bus where available in Kings County. If you do not agree with the eligibility determination, you have the right to appeal. Information on how to file an appeal will be included with your eligibility notice. If an eligibility determination takes longer than 21 days, you may be given eligibility that allows you to use the paratransit (Dial-A-Ride) system until a final decision about your eligibility is made. This does not apply if, through inactions on your part, we are unable to complete the processing of your application.

INSTRUCTIONS FOR APPLICANTS

1. Please **PRINT OR TYPE full responses to all of the questions** on the application form. Your detailed responses and explanations will help us make an appropriate determination. Be sure to **respond to ALL questions or your application will be considered incomplete**. Incomplete applications will be denied.
2. You are not required to attach additional pages or information. However, you may want to send other documents that you think will help us understand your limitations. **All information that you supply will be kept strictly confidential.**
3. **You must provide SIGNATURES in two places to complete the application:**
 - Applicant Certification (Page 8)
 - Authorization to Release Information for an appropriate medical or rehabilitation professional (Page 9)
4. **Return the completed application and photos to:**

**Kings Area Rural Transit
ADA Determinations
P.O. Box 209 – Hanford, CA 93232
Office Location 1340 NORTH Drive – Hanford, CA 93230
FAX 559-587-0714**

For help with the application process or to check on the status of your application call 559-582-3211 #2711 or 2717

Applicants are required to provide a small 1 inch by 1 inch photo. The photo will be used for a KART ID card identifying you as eligible for ADA service.

Thank you

Kings County Area Public Transit Agency (KART)
For schedules and route maps please visit our website at:
www.mykartbus.com

Please Print

Personal/Contact Information

Name *(first, middle, last)*:

Home Address: _____ Apt. #: _____

City: _____ Zip: _____

Mailing Address *(if different from home)*:

_____ Apt. #: _____

City: _____ Zip: _____

Daytime Phone: (____) _____ TDD/TTY: (____) _____

Evening Phone: (____) _____ Cell Phone: (____) _____

Birth Date: ____/____/____ Female Male

Primary Language *(please check)*: English Other *(specify)* _____

If you need any future written information provided to you in an accessible format, please check which format you prefer:

Audio tape Braille

In case of emergency, whom should we contact?

Name: _____

Relationship: _____

Day Phone: (____) _____ Eve. Phone: (____) _____

Tell Us About Your Disability / Health Related Condition

Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.

1. Which **disability (medical diagnosis) or health related conditions** **PREVENT** you from using KART without the help of another person?

2. Briefly explain **HOW** the above condition prevents you from using KART without the help of another person.

3. When did you first experience the conditions you described above?
 0 -1 year ago 1– 5 years ago Longer than 5 years

4. Do the conditions you described change from day to day in a way that affects your ability to use KART?
 Yes, good on some days, bad on others. No, doesn't change.
 Don't know.

5. Are the conditions you described?
 Permanent Temporary Don't Know

If temporary, how long do you expect this to continue?

Tell Us About Your Capabilities and Usual Activities

6. Do you use any of the following mobility aids or specialized equipment?
(Check all that apply):
- | | | |
|--|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Communication Devices |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Power Scooter | <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Portable Oxygen Tank | |
| <input type="checkbox"/> Other _____ | | |
7. Please check the box that best describes your current living situation:
- Live independently (without the assistance of another person)
 - 24 hour care or Skilled Nursing Facility
 - Live with family members who help me
 - Assisted Living Facility
 - Receive assistance from someone that comes to my home to Help with daily living activities
8. How many city blocks can you travel with your usual mobility aid and without the help of another person?
- 0 – 2 Blocks _____
- 3 – 6 Blocks _____
- 7 or more Blocks _____
9. Which of the following statements best describes you if you had to wait outside for a ride? (Check only one response):
- I could wait by myself for ten to fifteen minutes
 - I could wait by myself for ten to fifteen minutes only if I had a seat and shelter
 - I would need someone to wait with me because _____
-
10. Which of the following statements best describes you?
(Check only one response):
- I have never used KART
 - I have used KART but not since the onset of my disability
 - I have used KART within the last six months

Tell Us About Your Travel Needs

11. How do you currently travel to your frequent destinations?
(Check all that apply):

<input type="checkbox"/> Buses	how often: Weekly _____	Monthly _____
<input type="checkbox"/> Dial-A-Ride	how often: Weekly _____	Monthly _____
<input type="checkbox"/> Drive myself	how often: Weekly _____	Monthly _____
<input type="checkbox"/> Taxi	how often: Weekly _____	Monthly _____
<input type="checkbox"/> Someone drives me	how often: Weekly _____	Monthly _____

12. Do you travel with the help of another person?

Always Sometimes Never

If "always" or "sometimes", what type of help do they provide?

13. Would you be able to grasp handles or railings, coins or tickets while boarding or exiting a KART bus?

Yes No Sometimes Don't know, never tried it

If no or sometimes, explain why:

14. Would you be able to maintain balance and tolerate movement of KART when standing?

Yes No Sometimes Don't know, never tried it

If no or sometimes, explain why:

15. Would you be able to get to and from the KART stop nearest your home?

Yes No Sometimes

If no or sometimes, check why:

- More than 1/2 mile away
- Weather
- Curbs
- Sidewalks
- Street Crossings

16. Please add any other information that you would like us to know about your abilities.

Have you answered all the questions and provided explanations where required?

INCOMPLETE APPLICATIONS WILL BE DENIED.

Applicant Certification

I **certify** that the information in this application is **true** and **correct**. I understand that knowingly falsifying the information will result in denial of service. 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.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use KART in order to assist in the determination of eligibility.

Applicant's signature _____ **Date** _____

Did someone help you in filling out this form? Yes No

If yes, Name: _____ Phone: (____) _____

Relationship: _____

Please Note: It is your responsibility to notify us if your disability improves enough to change your eligibility status. If your condition improves after you have been determined eligible or we discover you submitted false

information, your eligibility could be suspended or you may be asked to re-apply.

Authorization to Release Medical Information

(to be completed by applicant)

I **hereby authorize** the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition, to release this information to Kings Area Rural Transit (KART). This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:

Address:

Telephone: _____ Fax: _____

Sign here:

Applicant's signature _____ Date _____

You may also attach any applicable documentation from your medical provider that may help determine your functional ability to use KART transportation services at the back of this form.

MEDICAL PROVIDER STATEMENT OF APPLICANT'S DISABILITY

(FOR PHYSICIAN USE ONLY)

<input type="checkbox"/> Physician	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Health Care Professional
<input type="checkbox"/> Rehabilitation Counselor	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Other (please specify _____)
Name of Professional Medical Provider: _____		
Address: _____		
Telephone: _____ Fax: _____		

The following examples are provided as guidelines only to assist the physician in his/her determination of the type of ADA Eligibility Certification appropriate for his/her patient:

- 1. Permanent / Unconditional Eligibility:** Any impairment which would cause the individual to become disoriented, confused, or otherwise incapable of navigating without the assistance of another person, and/or inability to physically reach a fixed boarding or disembarking location, or to physically board/disembark from a regular fixed route bus which is otherwise accessible.
- 2. Temporary / Transitional Eligibility:** Any temporary impairment (for a specified period of time renders the person disabled) which would cause the individual to become disoriented, confused, or otherwise incapable of navigating without the assistance of another person, and/or inability to physically reach a fixed board/disembarking location, or to physically board/disembark from a regular fixed route bus which is otherwise accessible.
- 3. Conditional Eligibility:** Any impairment that, dependent upon environmental conditions, terrain, vehicle accessibility, and/or facility accessibility, makes it impossible for the individual to independently board/disembark from any fixed route location. (this category is distinguished from the first category in that, the degree of disability of individuals in the first category prohibits them from using the fixed route system, while individuals in this category can use the fixed route within certain parameters.)

**MEDICAL PROVIDER STATEMENT OF APPLICANT'S DISABILITY
CONT.**

Under the Americans with Disability Act of 1990, individuals must meet one or more of the following criteria in order to be certified as ADA Eligible.

Please check the appropriate box or boxes, which best describes the applicant's condition.

_____ I certify that the above named individual, because of their disability, cannot **INDEPENDENTLY** board, ride, and/or disembark from any accessible wheelchair vehicle.

_____ I certify that the above named individual has a disability that **PREVENTS** him/her from getting to or from a boarding or disembarking location.

_____ I certify that the named applicant has a disability related condition (s) , however he/she is able to get to or from a fixed bus stop, board, ride, and disembark from any accessible wheelchair vehicle.

_____ I certify that the above named individual does not have a disability that qualifies as ADA eligible for public transportation.

Please List Qualifying condition (s):

_____ Permanent – The applicant's condition will not significantly improve.

_____ Temporary – The applicant's condition will likely improve. The anticipated term of present condition is _____ months.

Physician's Signature Only:

I certify that the information I have provided is true to the best of my knowledge.

Please print name: _____

Doctor's Signature: _____