KENOSHA AREA TRANSIT

ADA Paratransit Application

Care-a-Van paratransit service is door-to-door public transportation for people who are unable to ride a fixed route bus because of a physical or mental disability. This service is intended only for those trips that the person cannot make on the bus system. Completing this application form will help us to determine when and under what circumstances the applicant can use Care-a-Van buses and when Care-a-Van paratransit service is required. Before completing this application form, please read the enclosed guidelines that describe eligibility for ADA paratransit service in more detail.

INSTRUCTIONS FOR COMPLETING THIS FORM:

The applicant (or someone assisting them) must complete Parts 1-6. A licensed physician must complete and sign the Medical Verification page.

All questions must be answered. Incomplete forms will be returned.

If you need assistance in completing the form, or have any questions about ADA service and eligibility, please feel free to contact our office at:

(262) 653-4290 Voice
(800) 947-6827 TTY

WHEN COMPLETED, PLEASE RETURN THE ENTIRE FORM TO:

Kenosha Area Transit
4303 39th Avenue
Kenosha, WI 53144
FAX: (262) 653-4295

NOTE: THIS FORM REQUIRES ADDITIONAL POSTAGE IF MAILED

Dear Applicant:

There are two ADA Paratransit Eligibility Standards:

1. Your disability **prevents** you from navigating the system (i.e. getting on, riding, or getting off the bus) without the assistance of another individual. Please note that most Kenosha Area Transit buses are lift-equipped or ramp-equipped for the disabled.

2. Your disability **prevents** you from traveling to or from a bus stop location.

After reviewing the above, if you feel that your disability may fit into one of the standards, please continue with this application form. If you do not meet the criteria defined herein, please contact Kenosha Area Transit at (262) 653-4287 for information on fixed route bus service.

There are two types of ADA Paratransit eligibility:

1. Unconditional - this eligibility is granted if your disability prevents you from using Kenosha Area Transit bus service for any trips that you might need to make.

2. Conditional - this eligibility is granted if you can use buses some of the time, but need van service under certain circumstances.

The information you provide about your disability will be kept strictly confidential. Kenosha Area Transit staff will review your application and determine your eligibility. It is extremely important that your application be filled out completely. Any incomplete applications will be returned. Properly completed applications will be processed within 21 days of receipt. If you have not heard from us in 21 days, please call and we will provide you with van service until your application is processed. Please note that in some instances, we may not be able to determine your eligibility without further information. The submission of this application does not guarantee eligibility. Applicants will be notified in writing of the approval or denial of eligibility, and in the case of denial, the reason(s) for such. In the event that eligibility is denied, a description of the appeals process will be included with the written determination. If we determine that you are eligible for ADA service (either unconditionally or conditionally), a Care-a-Van Paratransit Guide will be sent to you, along with your Kenosha Area Transit identification card.

KENOSHA AREA TRANSIT – APPLICATION FOR PARATRANSIT SERVICES

SECTION ONE

PLEASE TYPE OR PRINT

For office use only:
Date Received _____
Status _____
Category _____
Effective Date _____
Expiration Date _____

1. Last Name _____

   First Name _____ M.I. _____

2. Address _____

   _____
   (Include facility name if applicable)

   City _____ State _____ Zip _____ - _____

3. Telephone number *(best number to reach you)* ( ) -

4. Date of Birth / /

5. Are you receiving Medicaid (MA)? *(Not to be confused with Medicare)* ☐ Yes ☐ No

Please answer the following questions in detail. Specific answers will help us in determining your eligibility. Incomplete applications will be returned to the applicant.

6. What is the disability that **prevents** you from using Kenosha Area Transit fixed route service?

   _____

   Is this condition temporary? ☐ Yes ☐ No If "Yes", the expected duration is until / /

7. **How** does your disability/health condition **prevent** you from using the city bus? **Please explain thoroughly.** *(Attach additional information if necessary.)*

   _____

   _____

   _____

8. When did you first experience the condition(s) described above?

   ☐ 0 - 1 year ago ☐ 1 - 5 years ago ☐ Longer than 5 years

9. Please check which best describes your current living situation:

   ☐ Skilled Nursing or Rehabilitation or Assisted Living Facility
   ☐ I receive assistance from someone that comes to my home to help with daily living activities
   ☐ I live with family or friends who help me
   ☐ I live independently (without the assistance of another person)

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

☐ Drive Myself ☐ City Bus ☐ Taxi

☐ Someone Drives Me ☐ Other *(please explain)* _____

11. Have you ever used Kenosha Transit buses?

☐ Yes ☐ No Why not? *(Please explain)* _____

_____

12. Are you **currently** able to use Kenosha Area Transit (city) buses for any of your transportation needs?

☐ Yes ☐ No I don't know *(explain)*

_____

_____

13. If provided with the appropriate training and practice, would you be able to use Kenosha Area Transit (city) bus service?

☐ Yes ☐ No Sometimes *(explain)* _____

SECTION TWO

NOTE: All Care-A-Van drivers, if requested, will assist riders on or off the bus and to the door of their destination.

1. When you travel, do you require the assistance of another person?

☐ Always ☐ Sometimes ☐ Never

2. What type of assistance do you need? *(Check all that apply)*

☐ Getting from the bus to my destination ☐ Communication ☐ Medication/Equipment assistance

☐ Transferring out of my mobility device ☐ Other _____

(If you require an attendant for your trips, that person, referred to as a Personal Care Attendant, is able to ride paratransit with you at no extra charge. A Personal Care Attendant is provided by the rider and is **not** a companion)

3. Which, if any, of the following mobility aids do you use? *(Check all that apply.)*

☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Electric Scooter ☐ Walker

☐ Guide Animal ☐ White Cane ☐ Cane ☐ Crutches

4. If you use an **oversize** wheelchair or electric scooter, please provide the following information:

Make/Model _____ Size of device: Length _____ Width _____

Does the total weight of your wheelchair or scooter and yourself exceed 600 pounds?

☐ Yes ☐ No

The Americans with Disabilities Act (ADA) of 1990 only requires public transportation programs to serve those individuals in a "common wheelchair?" The ADA defines a "common wheelchair" as a mobility device that is **no more than 30 inches wide, 48 inches long or weighs more than 600 pounds when occupied.**

If your mobility device exceeds these dimensions, the ADA does NOT guarantee your paratransit service.

5. Please answer all the following questions about your mobility, including while using a mobility device:

Can you travel from your residence to the curb or roadside without assistance?

☐ Yes ☐ No ☐ Sometimes _____

Can you travel one block without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you travel ¼ mile (2-4 city blocks) without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you travel ¾ mile (6-8 city blocks) without the assistance of another person?

☐ Yes ☐ No ☐ Sometimes _____

Can you wait outside without support from another person for 10 minutes?

☐ Yes ☐ No ☐ Sometimes _____

Can you make your way to a bus stop?

☐ Yes ☐ No *(Check all that apply to you)*

- ☐ I cannot find the stop because I get confused.
- ☐ I cannot travel to the bus stop without assistance from another person.
- ☐ I cannot cross the street.
- ☐ Heavy rain/snow makes it impossible for me to get there.
- ☐ Other _____

6. Please answer all the following questions about your abilities:

Are you able to give your address, destination and phone number upon request if needed?

☐ Yes ☐ No ☐ Sometimes _____

Are you able to recognize a destination or landmark?

☐ Yes ☐ No ☐ Sometimes _____

Are you able to allow you to ask for, understand and follow directions?

☐ Yes ☐ No ☐ Sometimes _____

Do you use a communication aid?

☐ Yes ☐ No If "Yes", please specify the device _____

List the names of two people who may be contacted in case of an emergency:

Name _____ Telephone # ( ) - _____ (H)

Relationship _____ ( ) - _____ (W)

Name _____ Telephone # ( ) - _____ (H)

Relationship _____ ( ) - _____ (W)

Do you need to have information and material given to you in any of the following ways*? (check all that you need)*

☐ Large Print ☐ Audio Tape ☐ Other: _____

End of application. Please proceed to Certification Statement and Release of Medical Information Authorization.

Certification Statement and Release of Medical Information Authorization (Applicant)

I understand that the purpose of this evaluation form is to determine if there are times when I cannot use the bus service provided by Kenosha Area Transit and must therefore use paratransit service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this evaluation form is true and correct. I understand that providing false or misleading information could result in my eligibility status being re-examined as well as other actions by Kenosha Area Transit.

I hereby authorize the below professional to provide the required information to Kenosha Area Transit. I certify that the information here and on the preceding pages is correct. I understand that falsification of information may result in denial of service.

Applicant's signature: _____ Date: _____

Physician Name: _____

Facility: _____ Address: _____

City: _____ State: _____ Zip: _____ - _____

Telephone Number: ( ) - _____ Fax: ( ) - _____

Please mail or fax this COMPLETED application form to:

Kenosha Area Transit
4303 39th Avenue
Kenosha, WI 53144
(262) 653-4290
(262) 653-4295 (FAX)

Please note that you will be contacted via telephone if you need to be evaluated in person. All applicants will receive a letter within 21 days of receipt of the **completed** application with a determination. If you are denied, information about the appeals process will be provided.

THIS ENDS THE PORTION OF THE FORM TO BE COMPLETED BY THE APPLICANT. THE LAST SECTION (ON THE FOLLOWING PAGE) MUST BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN.

MEDICAL VERIFICATION *(to be completed by a licensed physician)*

Care-A-Van paratransit service is door-to-door public transportation for people who are unable to ride a fixed route bus because of a disability. The applicant who has asked you to review and sign this form is applying to Kenosha Area Transit to be considered eligible for this service. Paratransit service is intended only for those trips that the person cannot make on the bus system. Please note that most Kenosha Area Transit buses are lift or ramp equipped.

This application form is intended to determine ***when and under what circumstances the applicant can use Kenosha Area Transit buses and when they require paratransit service.***

Please carefully review the information provided by the applicant of this form, and answer the questions below.

(a) Please describe the physical and/or cognitive condition which functionally prevents the applicant from using standard Kenosha Area Transit bus service:

_____

_____

_____

(b) To the best of your knowledge, is the information provided by the applicant true and correct?

☐ Yes ☐ No *(Note exceptions or additions below)*

_____

_____

_____

Print Physician Name and Title: _____

Physician Signature: _____ Date: / /

State of Wisconsin Medical License #: _____

Business Name: _____

Street Address: _____

City / State: _____ Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) -