

Certification of ADA Paratransit Eligibility

THE INFORMATION OBTAINED IN THIS CERTIFICATION PROCESS WILL ONLY BE USED BY KVRTA FOR THE PROVISION OF TRANSPORTATION SERVICES. INFORMATION WILL ONLY BE SHARED WITH OTHER TRANSIST PROVIDERS TO FACILITATE TRAVEL IN THOSE AREAS. THE INFORMATION WILL NOT BE PROVIDED TO ANY OTHER PERSON OR AGENCY.

1. NAME _____
2. ADDRESS _____
CITY _____ STATE _____ ZIP _____
3. TELEPHONE NUMBER (____) _____ WORK (____) _____
4. EMERGENCY CONTACT PERSON _____
EMERGENCY NUMBER (____) _____
5. DATE OF BIRTH _____ / _____ / _____

6. WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING OUR FIXED ROUTE SERVICE? _____

IS THIS CONDITION TEMPORARY? _____ IF YES, EXPECTED DURATION TIL _____ / _____ / _____

7. HOW DOES THE DISABILITY PREVENT YOU FROM USING FIXED ROUTE SERVICES?

PLEASE EXPLAIN COMPLETELY. USE ADDITIONAL SHEET IF NEEDED. _____

8. ARE THERE ANY OTHER EFFECTS OF YOUR DISABILITY OF WHICH WE NEED TO BE AWARE? _____

THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE BY KVRTA.

9. DO YOU USE ANY OF THE FOLLOWING AIDS FOR MOBILITY? (CHECK ALL THAT APPLY)

MANUAL WHEELCHAIR____ ELECTRIC WHEELCHAIR____ POWERED SCOOTER____

CANE____ CRUTCHES____ GUIDE DOG____ WALKER____

10. WILL YOU TRAVEL WITH A PERSONAL CARE ATTENDANT?

YES____ NO____

11. PLEASE ANSWER THE FOLLOWING QUESTIONS:

CAN YOU TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES____ NO____ SOMETIMES_____

CAN YOU TRAVEL ¼ MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES____ NO____ SOMETIMES_____

CAN YOU TRAVEL ¾ MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON?

YES____ NO____ SOMETIMES_____

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE?

YES____ NO____ SOMETIMES_____

CAN YOU WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES?

YES____ NO____ SOMETIMES_____

12. I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT.

SIGNED_____ DATE____/____/____

13. DO YOU HAVE MEDICAID?

YES____ NO____

14. IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION, THAT PERSON MUST COMPLETE THE FOLLOWING:

NAME _____

ADDRESS _____

DAYTIME PHONE (____) _____

SIGNED _____ **DATE** ____/____/____

IN ORDER TO ALLOW KVRTA TO EVALUATE YOUR REQUEST, IT MAY BE NECESSARY TO CONTACT A PHYSICIAN OR OTHER TREATING PROFESSIONAL TO CONFIRM THE INFORMATION YOU HAVE PROVIDED. PLEASE COMPLETE THE FOLLOWING INFORMATION AND AUTHORIZATION FORM.

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____

I authorize KVRTA to contact my treating professional to discuss the information in this application.

PATIENT NAME(PRINT) _____

PATIENT SIGNATURE _____ **DATE** _____

RETURN FORM TO: KRT

P.O. BOX 1188

CHARLESTON WV 25324