

APPLICATION FOR A.D.A. PARATRANSIT ELIGIBILITY

Topeka Metro Lift Service

820 SE Quincy St., Topeka, KS 66612-1114

785-783-7000 (phone) or 785-354-8476 (fax)

**Part 1. All questions must be answered by applicant (only one applicant per form).
Incomplete forms will be returned. Please type or print - use separate sheet if needed.**

Applicant Name: _____ Birthdate: _____ Age: _____

Address: _____ Zip Code: _____
(Address is a: Group Home Assisted Living Apartment Care/Nursing Facility _____ (Other)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Circle one: Original application or Re-certification application

I.D. Number (if re-certifying): _____ Gender _____

1. Please describe your current disability? **(Be specific & list all applicable disabilities that affect mobility):**

2. How does this disability **prevent** you from using the fixed route bus system? **Please keep in mind that all fixed route buses are wheelchair accessible.**

3. Is your disability or health condition: _____ Permanent _____ Temporary
If temporary, what is the expected duration? _____/_____/_____

4. If your disability or health condition changes from day-to-day, please explain how:

5. Does your disability prevent you from getting to and/or from a fixed route bus stop? _____ Yes _____ No

6. How far can you travel with a mobility aid? _____(blocks) Walk in blocks? _____(blocks)

7. Do changes in weather prevent you from getting to or from a bus stop? _____ Yes _____ No
If yes, list specific weather conditions and its impact on your mobility: _____

8. If there is a physical barrier that, when combined with your disability, might prevent travel to or from the bus stop closest to you, please list it: (Examples: no sidewalks, no curb cuts, ice, snow, no crosswalks/lights, steps)

9. Are you prevented from traveling to or from a boarding location for any of the following reasons? (check all that apply):

- Inability to negotiate hilly terrain Extreme sensitivity to climatic conditions
- Allergic/environmental sensitivities Hyper-fatigue or frailty
- Night blindness Inability to cross busy intersections
- Other (please explain): _____

10. Can you wait ten (10) minutes alone at a bus stop? Yes No

11. Can you climb three (3) steps to get into a bus? Yes No

12. Can you board a bus with a “kneeling” feature which lowers the height of the first step? Yes No

13. Can you transfer from one bus to another? Yes No

14. Can you follow written instructions? Yes No Oral instructions? Yes No

15. Can you use the telephone or TTD to make calls? Yes No

16. Are you able to identify the bus you need? Yes No

17. Are you able to detect curbs, curb cuts, sidewalks, etc.? Yes No

18. Are you legally blind? Yes No

If yes, what is your visual acuity? _____ right eye _____ left eye

19. Please check all of the following mobility aids you might use. **Circle your primary mobility aid.**

- Manual wheelchair Electric wheelchair Power scooter Walker
- Support cane White cane Oxygen tank Crutches
- Ambulatory, but must use lift/ramp to board vehicle I do not use a mobility aid of any kind
- Service/guide animal – task it is trained to do: _____
- Other: _____

20. If you utilize a wheelchair or scooter, please list the manufacturer & model and number of wheels:

21. If you use a wheelchair or scooter, what are its physical dimensions when measured 2 inches above the floor, including foot or head extensions (in inches)?

_____ width _____ height _____ length _____ weight

22. Do you require a Personal Care Attendant (PCA) when you travel? *Note: A PCA is someone who is designated or employed by a person to provide personal assistance; it is not a companion or escort.*

Yes No Sometimes

23. Do you require a reasonable modification in order to utilize Topeka Metro services? Yes No

If yes, what modification do you request? _____

24. Do you currently ride the fixed route system? ___ Yes ___ No If yes, how often? ___ / per week

25. Did you ride the fixed route system in the past? ___ Yes ___ No

26. Would you like to receive information on the fixed route system? ___ Yes ___ No

Please provide a contact name and phone number of a relative or friend in case we are unable to reach you:

Name: _____ Relationship: _____

Telephone: _____ (home) _____ (work) _____ (cell)

I hereby certify, to the best of my knowledge, that the information I have provided in this form is correct and true. Falsifying information is prohibited and could result in permanent suspension of my Lift eligibility. In addition, I agree to notify Topeka Metro of any changes in my status, that may affect my eligibility to use this service. I also understand that failure to adhere to the policies and procedures identified in the Lift User’s Guide will be grounds for revoking my right to participate in the Lift program. I hereby authorize my agency representative or health care professional(s) to provide any additional information to Topeka Metro personnel as needed or requested.

Signature of applicant: _____ Date: _____

Applicant safety is an utmost concern for Topeka Metro. Shawnee County Emergency Management has a database of individual names, address and phone number who may require assistance during or after a disaster situation within our county. By signing in this section, you give Topeka Metro permission to provide this data to Shawnee County Emergency Management. Data would be saved on a Shawnee County Emergency Management secure hard drive.

Signature of applicant: _____ Date: _____

If you are not the applicant, but have completed this application on the applicant’s behalf, you must provide the following information (please type or print):

Your name and address: _____

Daytime telephone: _____ Relationship to applicant: _____

I hereby certify, to the best of my knowledge, that the above information is true and correct.

Signed: _____ Date: _____

LIFT DEPARTMENT USE ONLY

_____ *New Application*

_____ *Re-certification*

Date Received: _____ *Determination:* *Full* *Conditional* *Temporary* *Denied*

Terms for conditional approval: _____

Within 3/4 Corridor? _____ *Within City Limits?* _____

I.D. #: _____

Date Issued: _____ *Expiration Date:* _____

Eligibility Code: _____ *PCA:* *yes* *no* *sometimes*

Special Instructions/Reasonable Modifications: _____

Part 2 – Request for Professional ADA Certification

(All questions must be answered by a Physician, Health Care Professional or Agency Representative.)

You are being asked by the applicant named in Part I to provide information regarding his/her ability to use public transit services. Topeka Metro will provide origin to destination paratransit services to persons who, due to a disability, are unable to use the city’s fixed route bus system. **(Please note all city fixed route buses are low-floor vehicles equipped with wheelchair ramps and securement devices for people who use a wheelchair or cannot climb stairs.)** The information you provide will allow us to evaluate the request and provide service to those qualified in accordance with Americans with Disabilities Act (ADA) regulations.

Mere difficulty, apprehension or inconvenience in using the fixed route system does not make a person eligible for paratransit service. (Examples: A person who prefers not to use the fixed route due to inclement weather is **not** ADA eligible unless the weather, in combination with their disability, prevents travel to or from a bus stop. A person with a disability who must exert him or herself to use the fixed route system is **not** ADA eligible unless the required exertion exceeds the limitations of the person’s disability.)

Capacity in which you know the applicant: _____

Please identify the applicant’s disability and describe the impacts or limitations to mobility: _____

Is this condition temporary? Yes No If yes, expected duration ____/____/____

If the applicant has a visual impairment, please identify extent of impairment and describe how it **prevents** their use of the fixed route bus system: _____

If the applicant has a cognitive disability, please identify extent of impairment and describe how it **prevents** their use of the fixed route bus system: _____

In your professional opinion, is this person **unable** to use the fixed route bus service? Yes No

I hereby certify that the above information is true. I understand that false certification may be reported to the appropriate licensing body or certifying authority.

Signature (or stamp) _____ Date _____

Print name _____

Address _____ City _____ State ____ Zip _____

Daytime telephone _____ License # _____ State _____

Agency: _____ Profession: _____

**Please fax fully completed application to 785-354-8476 or mail to: The Lift Service
820 SE Quincy St.
Topeka, KS 66612-1114**