KINGSPORT AREA TRANSIT SERVICE

APPLICATION FOR ADA PARATRANSIT SERVICE ELIGIBILITY

The Federal Americans with Disabilities Act (ADA) requires comparable public transportation services for persons with disabilities who are unable, because of their disability to use a regular fixed route KATS Bus service. This service is only for Kingsport residents or visitors that have been certified ADA eligible by another transit provider.

If you believe you have a disability or a need that prevents you from using the regular KATS bus fixed route service, please complete this application and return it to the address below to determine your eligibility.

It is important to note that all parts of this application must be completed, including the sections required by the Health Care Professional. **You as an applicant are responsible for the completion of this entire application form.** Incomplete applications will be returned to you.

KATS will review your application and follow-up as necessary to determine your eligibility for ADA paratransit service. KATS will notify you within 21 days of receiving your **completed application** regarding your eligibility for ADA paratransit service. If you have not heard about your eligibility status within 21 days of submitting your application, please call 423-224-2613. If a determination has not been made yet, you will be temporarily eligible.

If you have any questions or concerns about your eligibility status or you need assistance in filling out the application, please call (423) 224-2613.
All information will be kept confidential.

Thank you for choosing KATS; we look forward to serving you!

PLEASE SEND A COMPLETED ORIGINAL (faxed copies not accepted) APPLICATION TO:

Kingsport Area Transit Service
109 Clay Street
Kingsport, TN 37660

For questions regarding the ADA Paratransit Service, please contact us at:

Telephone: (423) 224-2613
Email: katsvan@kingsporttn.gov

KINGSPORT AREA TRANSIT SERVICE
Application Form for ADA Paratransit Service Eligibility

SECTION I
APPLICANT INFORMATION

☐ First Time Applying ☐ Renewal ☐ Re-Applying

Check (1) title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐Other____________________(Dr./Rev., etc.)

Name: ________________________ ____________________________ ________
Last First Middle Initial

Mailing Address: ____________________________ ______________ _______ __________
P.O. Box or Street City State Zip Code

Residence Address: ___________________________ ______________ _______ __________
Street/Apt. # City State Zip Code

Date of Birth: ____________________ **Phone**: __________________ __________________
Month/Day/Year Home/Work Mobile

Emergency Contact: ___________________________ **Relationship**: ____________________

Home/Work Phone: ____________________________ **Mobile**: ________________________

1. Please describe your disability and explain in detail how it prevents you from using the regular KATS Bus fixed route service:

____
____
____
____

2. My condition is:

☐ Permanent ☐ Long-Term / Temporary ______________________________
(Expected Duration)

3. Are there any other conditions that limit your ability to use the KATS bus?

☐ Yes ☐ No If **YES**, please explain ____________________________________
____
____
____

Section II-Mobility Information

Mobility Status: (Please check all that apply)

☐ Uses Cane ☐ Uses Walker ☐ Uses Crutches ☐ Service Animal ☐ Need to use lift instead of steps

☐ Requires Portable Oxygen ☐ Requires Personal Care Attendant ☐ Other:________________________

☐ Manual Wheelchair Length: _________ Width: _________

☐ Motorized Wheelchair Length: _________ Width: _________

☐ 3-Wheel Scooter Length: Width: _________

**wheelchairs/scooters cannot exceed 48” in length and 30” in width and 600 pounds when occupied.

4. Using a mobility aid or on your own, how many blocks can you walk on level ground (1 block = 500 feet)?

   Number of Blocks: ____

5. Do you require a Personal Care Attendant (PCA) or escort to accompany you when you travel? (Please note that if you check yes or your doctor requires you to have a PCA, this person, provided by you will need to accompany you at ALL TIMES).

   ☐ Yes ☐ No

   If you checked **YES**, please list the name(s) of your PCA (agency) or escort:

   Name:____

   Address:____

   Telephone:____

6. Where is the nearest bus stop to your home? (Example: West Center and Clay St.)

   ____

7. Can you climb three (3) steps without assistance? ☐ Yes ☐ No

8. Is your ability to travel or wait outdoors affected by extreme hot or cold weather conditions?

   ☐ Yes ☐ No If **YES**, please describe conditions you cannot tolerate.

   ____

9. Are you able to board or disembark from a KATS Bus with a wheelchair lift?

   ☐ Yes ☐ No If **NO**, please explain

   ____

10. Are you able to get around independently without assistance?

    ☐ Yes ☐ No If **NO**, please explain

    ____

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

    ☐ Yes ☐ No If **NO**, please explain

    ____

12. How did you learn of the KATS Paratransit service?

    ____

In order for Kingsport Area Transit Service (KATS) to evaluate your application, it is necessary to contact a health care professional to verify the information that you have provided. Your signature below will provide that authorization. If you need transportation in order to obtain this information from your health care professional, please let us know. A trip to your health care professional and back home can be provided to you for normal fare.

I hereby certify that the information provided in this application is correct. I authorize the release of information to Kingsport Area Transit Service (KATS). I also authorize KATS to contact the health care professional who completed Section III of this application to release information regarding my disability to KATS. The information about my disability will be used solely to determine my eligibility for paratransit services.

Applicant's Name (Print):___________________________ Date:_________________

Applicant's Signature:____

Please list the names of your health care professional (**licensed physician, or nurse practitioner**) designated by the applicant, who may be contacted by KATS.

Name of Health Care Professional: ____

Office/Mailing Address: ____

City: _______________________________ State: _________ Zip Code: _________

If you are NOT the applicant but have completed this application on the applicant's behalf, you must provide the following information:

Full Name (Print):____

Mailing Address: ____

City_______________________ State_________________ Zip Code_______________

Relationship to Applicant________________________ Daytime Phone_______________

I hereby certify that to the best of my knowledge the information given above is correct and can be verified by the applicant's heath care professional.

Signature:_____________________________________ Date:___________________

You have now completed the applicant section of the ADA Paratransit Eligibility Form. Please give this entire Application to the Health Care Professional most familiar with your abilities and disabilities.

Section III Healthcare Professional Verification

KINGSPORT AREA TRANSIT SERVICE
VERIFICATION OF PARATRANSIT ELIGIBILITY

Health Care Professional Verification of Applicant's Disability and Functional Capabilities

This portion of the application form is to be completed by the Health Care Professional, most familiar with the applicant's abilities and disabilities, as they relate to using regular fixed route KATS Bus Service.

The attached applicant has applied for ADA paratransit service with Kingsport Area Transit Service (KATS). You are being asked to provide information regarding this applicant's disability **as it affects their ability to use the regular fixed route public transportation (KATS Bus) service.**

KATS provides paratransit (Curb-to-Curb) service to persons who cannot use the regular fixed route Bus.

To assist our office in determining eligibility status, please review the enclosed information completed by the applicant, and complete the attached verification of paratransit eligibility form.

Please note: Your certification should consider only the presence of a disabling condition(s) and its affect(s) upon the applicant's ability to use the KATS Bus. They must be unable to independently get to or from bus stops, ride the KATS Bus, and/or navigate (find their way) the system. This verification is one step in determining an applicant's eligibility for paratransit service. Final approval of eligibility is made by the Kingsport Area Transit Service.

Should you have any questions regarding ADA paratransit eligibility, please contact the Kingsport Area Transit Service at 423-224-2613.

PLEASE SEND COMPLETED APPLICATION TO:

Kingsport Area Transit Service
Attention: ADA PARATRANSIT SERVICE
109 Clay Street
Kingsport, TN 37660

Section III Healthcare Professional Verification
Signature Required

Capacity in which you know the applicant:_______________________________

Medical Diagnosis of condition causing disability:___________________________

____

____

The condition is:

□ Temporary: Expected duration until_______/___/_____

□ Long Term: Conditions with potential for improvement or long periods of remission.

□ Permanent: Condition with no expectation of improvement.

In your professional opinion, is this person eligible or do they have a need for a specialized transportation service such as KATS paratransit?

□ YES □ NO

Need for Personal Care Attendant:
Does the individual require a Personal Care Attendant when traveling, using transit?

□ YES □ NO

Please Note: Individuals that are diagnosed with any level of cognitive disability such as Dementia or Alzheimer's may be classified as Conditional Eligibility with conditions requiring them to be transported with a Personal Care Attendant (PCA) for safety reasons.

I hereby certify that the above information is true. False verification may result in the disqualification of the application.

____ ________________
Signature Date

Print Name ____________________________________ Title _____________

Address ____

City ___________________________ State ___________ Zip Code _____________

Telephone ____