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.

Upon receiving your fully completed application, KATS will come to your residence in order to do a site check; this is part of the Dial A Ride eligibility process. The site check is to ensure that the loading conditions at your home are safe for both the passenger and KATS employee. KATS will bring a vehicle to your home for the site check to ensure proper lift capability and safe loading conditions.

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. Requests for ADA reasonable modifications may be submitted and will be processed upon request. For more information on the "KATS Reasonable Modification Policy", please visit our website at www.kingsporttransit.org
All information will be kept confidential.

All KATS information is available in Accessible Formats upon request.

PLEASE SEND A COMPLETED ORIGINAL APPLICATION TO:

Kingsport Area Transit Service
900 East Main Street
Kingsport, TN 37660

For questions regarding the Dial A Ride Paratransit Service, please contact us at:

Telephone: (423) 224-2613 or Fax: 224-2615

KINGSPORT AREA TRANSIT SERVICE
Application Form for ADA Dial A Ride 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 800 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, for your safety, KATS suggests that the PCA should accompany you on your trip.)

   ☐ Yes ☐ No

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

   Name:_____

   Address:_____

   Telephone:_____

6. Does your Personal Care Attendant (PCA) use any mobility aids? If so, please list.

   _____

Section II-Mobility Information Continued

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 from the threshold of your home to the KATS van independently?

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

    _____

11. Do you have a clear and safe path from your door to the van?

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

    _____

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

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

    _____

13. How did you learn about the KATS Dial A Ride 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. I also authorize KATS to complete a site check at my place of residence prior to eligibility. KATS reserves the right to conduct a site check at any time if safety or loading conditions are in question.

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. **Fax No: 423-224-2615**

PLEASE SEND COMPLETED APPLICATION TO:

Kingsport Area Transit Service
Attention: Dial A Ride ADA SERVICE
900 East Main Street
Kingsport, TN 37660

Section III Healthcare Professional Verification
Signature Required

Applicant Name:_____

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 the KATS Dial A Ride transportation service?

□ YES □ NO

Need for Personal Care Attendant:
Does the individual require a Personal Care Attendant when traveling, using transit? (personal care attendant must be provided by applicant)

□ 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 _____