SPIRIT OF KOKOMO
ADA PARATRANSIT ELIGIBILITY APPLICATION

Functional Ability Assessments may be required. This assessment will take between an hour and an hour and a half to complete. A transit eligibility determination will be decided within 21 days of receipt of the application. You will be notified of the outcome of eligibility determination in writing.

If the applicant is denied certification, they may file an appeal in writing within 30 days of the date of the denial. Send appeal request to the – Spirit of Kokomo ADA Appeals Committee. Written appeal requests may be sent via USPS mail, fax, email, or in-person.

219 E. Sycamore St., Kokomo IN. 46901,
Transportation@cityofkokomo.org or,
fax to 765.456.7239

I have read and understand the Rider's Guide which can be found at www.cityofkokomo.org for the use of the Spirit of Kokomo and agree to abide by the rules and policies set by the transportation department. I understand that knowingly falsifying the information will result in disqualification of service. I understand that the use of information provided herein is intended for the sole purpose of establishing eligibility for the **Spirit of Kokomo ADA Paratransit System.** Information will be treated as private and will not be released to any person, agency, institution, or organization without my express permission.

____ __________________
Signature of Applicant Date

Once an applicant has been certified, a Spirit of Kokomo team member will call the applicant to discuss how to use the Paratransit System and schedule their first trip to the Trolley Station to provide the required photo identification and any additional documents needed. At this time, the rider may begin scheduling trips and using the SPIRIT of KOKOMO.

FOR SPIRIT OF KOKOMO OFFICE USE ONLY

Date Application Received: _____ / _____ / _____

Received by: ______________________________ Received by: Person Fax Mail Email

Approved by: ______________________________ Mailed Info: _____/_____/____

Date Approved/Denied _____/_____/_____ Recertification due: _____/_____/_____

This form and the Professional Verification form MUST be COMPLETELY filled out in order to be processed. Please note: These may be a two (2) sided document.

Please check one of the following:

_____ New application (you are NOT a current paratransit rider)

_____ Request for re-certification (you have been asked to update your current application)

PLEASE READ CAREFULLY: Because the ADA requires paratransit service **only for people who are unable to use the fixed route service due to a disability**, eligibility determination focuses solely on the person's **functional ability** to use the fixed route service**. Applicants may be required to attend an in-person functional ability assessment to help determine eligibility. Refusal to do so will halt application.**

Name ____
Last First Middle Int.

Date of Birth ________/_______/________ Current Age: ______ Male ________ Female_________
Month Day Year

Street Address ____Apt/Ste # _______________

City, State ____ Zip Code _______________

Phone numbers: ( ) _________________________Home ( ) __________________________Cell

Do you have a current Indiana Driver's License or Picture ID? The Spirit of Kokomo requires proof of identity ___Yes ___No State of issue: ______ # ________________________ Yr. Exp ________

Have you qualified for paratransit services in another area? ______Yes ______No

If completing this application on the applicant's behalf, you must provide the following information:

Your Name ____

Address ____

City ____State __________________ZIP_________________

Daytime Phone Number ( ) ________________________

Voluntary participation: Statistical purposes only, no bearing on eligibility determination:

Monthly Income: ______ Above $1,133.00 ______Below $1,133.00

Race: ______ Caucasian ______African – America ______ Hispanic ______ Asian Pacific

______American Indian/Alaskan ________Other

Difficulty speaking, reading or understand English? ________ Yes ________ No.

Preferred language? ____

Emergency Contact: ___________________________________ **Phone:** ______________________________

Disability Information:

Please tell us what type of disability or health issue(s) keep you from using the City-Line fixed route bus services? Check all that apply:

_____ Physical _____Mental _____ Blindness/Visual Impairment _____ Deaf/Hearing Impairment

_____ Cognitive/Developmental _____Health Issues ______Other

If "other" please provide detailed explanation: ____

____

Do you use any of the following mobility aids? _____ Manual Wheelchair _____ Motorized Wheelchair

_____ Motorized Scooter _____ Prothesis/Braces _____ Crutches _____ Service Animal _____ Walker

_____ Portable Oxygen Tank _____ White Cane ______ Other: ____________________________________

Please explain in detail how/why your disability and/or health issue(s) keep you from using the fixed route bus services: What are the specific conditions of your disability which LIMIT YOUR FUNCTIONAL ABILITY? It cannot just be "difficult or inconvenient" for you to travel on a fixed route bus?

____

____

City-Line Trolley fixed route system:

Are you able to travel to the nearest bus stop or the transfer station at 219 E. Sycamore St.?

□ Yes
□ No, please explain: ____

____

Are you able to wait 30 minutes or longer at a bus stop or at the transfer station at 219 E. Sycamore St.?

□ Yes
□ No, please explain: ____

____

Are you able to identify the correct bus?

□ Yes
□ No, please explain: ____

____

Are you able to independently climb 3 steps?

□ Yes
□ No, please explain: ____

____

Are you able to keep balance while seated on a moving vehicle?

□ Yes
□ No, please explain: ____

Are you able to understand and/or process information which is needed to make necessary decisions during a trip?

□ Yes
□ No, please explain: ____
____

Are you able to communicate with a bus driver?

□ Yes
□ No, please explain: ____
____

Do you currently use the fixed route system?

□ Yes, which routes? ____

When is the last time you independently used the fixed route system? ____________________________
____

What is it about riding a fixed route bus that is most difficult for you? List as many things as you can think of. Please explain: ____
____
____

Do you think you might benefit from travel training? _______ Yes _______ No _______don't know

Concerns: ____
____

What other means of transportation have you recently used? Please check all that apply

_______ Drove my own vehicle _______ Rode with family/friends _______ Taxi/Cab Service

_______ Medical Transport Companies Other modes of transportation (please describe): ____________

Where would you usually be traveling? Please check all that apply:

_________ Employment/Job _________ Shopping _________ Recreation/Visiting ________ School

________ Medical/Dialysis Treatment ________ Other _______________________________________

Release of Information Form

To be submitted with the application for Spirit of Kokomo Paratransit Services.

AUTHORIZATION: Applicant must complete this page before giving the entire form to the professional named below.

Applicant's Name ____

Last First Middle Int.

Date of Birth __________/__________/___________ Current Age _______________

Applicant's Street Address ____

City/Town ___________________________ Zip Code ____________________

Phone numbers: Cell ( ) _______________________ Home/Other ( ) _____________________

I hereby authorize the following certifying professional(s) to release to The Spirit of Kokomo specific information as requested. It is my understanding that this information will be used solely to determine my ADA Paratransit eligibility. I understand that I may revoke this authorization at any time. Unless revoked, this form will allow the professional named below to release information described for three (3) months after the date which appears below.

Printed name of professional(s) ____

____

Telephone number of professional ( ) ____

____ General/Family physician ____ Physician/Specialist ____ Psychiatrist/Psychologist

____ Licensed Optometrist ____ Certified Audiologist ____ Certified Rehabilitation Specialist

____ Other (please describe): ____

Applicant's Signature ____________________________ Date: _______/______/________

Month Day Year

Signing for applicant___________________________ Printed Name ___________________________

Relationship to applicant: ____

MEDICAL/PROFESSIONAL PROVIDERS

IMPORTANT! ***PLEASE READ***

GUIDELINES FOR MEDICAL/PROFESSIONAL FORM
TO ASSURE RAPID ELIGIBILTY DETREMINATION FOR APPLICANT

By completing and signing, you certify to the truth and accuracy of the information provided on the Medical/Professional Verification Form to the best of your professional knowledge.

The American with Disabilities Act of 1990: 49 CFR Part 37, requires transportation providers offer Paratransit service **only** for people who are **unable** to use the fixed route service due to a disability.

Eligibility determination focuses **solely** on the person's **functional ability** to use the fixed route service.

Along with the Medical/Professional form attached the provider **MUST** include support documentation that ties the lack of functional ability to use the fixed route with the applicant's disability. The supporting documentation can be, chart notes/records, physical assessment reports, a letter detailing functional limitations, etc. (prior to the application date, unless the condition is a new onset).

The Spirit of Kokomo may no longer accept a provider's opinion letter as justification for transportation on the Spirit of Kokomo Paratransit. We must show the applicant meets paratransit criteria to be approved.

There is no automatic ADA eligibility based on a diagnosis, disability, or a mobility aid used. This is a transportation decision, not a medical decision. People have to be **unable** to use the fixed route system. This can be all of the time, or in certain situations, **as opposed to something that is difficult, uncomfortable, or inconvenient,** which using fixed route transit often is**.**

- We must show an absence of FUNTIONAL ABILITY to use the fixed route system.

Please do not forget to send the support documentation that links the inability to use the fixed route system with the applicant's disability. Please remove any medical information that is not associated with this determination process**.**

If you have any questions regarding The Spirit of Kokomo Paratransit System or these forms, feel free to contact us at:
765-456-7556.

Thank you for taking time to help us identify if your patient/client qualifies for our ADA complementary paratransit system.
Please mail, email or fax completed form to:
Spirit of Kokomo
219 E. Sycamore St.
Kokomo, IN 46901
E-mail: Transportation@cityofkokomo.org
Fax: 765-456-7239

MEDICAL/PROFESSIONAL VERIFICATION FORM

By completing and signing, you certify to the truth and accuracy of the information provided on the Medical/Professional Verification Form to the best of your professional knowledge

Please provide information regarding the applicant's abilities; taking into consideration any mobility aid device(s) and the fact the fixed route vehicles are completely ADA accessible (lift/ramp equipped). **Please supply detailed support documentation with this application to help us determine functional ability.**

Applicant's Name____ Date of Birth __________________

1) In what capacity do you know this individual? ____

2) How long have you known this individual? ____

3) What are the last 2 (two) dates of face-to-face contact (by you or your agency) with this individual?

   ________/________/________ ________/________/________
   Month Day Year Month Day Year

4) Primary Disability (Please list ICD-10 diagnosis codes) ____________________________________

   Date(s) of onset? ________/________/_________ ________/________/_________
   Month Day Year Month Day Year

5) Secondary Disability? ____

6) Is this condition temporary? □Yes, how long? ____________________ □ No

7) Currently receiving treatment?

   □Yes, what type? ____

   □ No, why not? ____

8) What is the prognosis? ____

9) Are the effects of the disability variable?

   □ Yes, please explain ____

   □ No, please explain ____

10) Is the disability controlled by medication?

   □ Yes, please explain ____

   □ No, please explain____

11) When taking medication compliantly, is the individual more likely to be able to travel independently, utilizing the City-Line Trolley fixed route bus system?

   □ Yes □ No, why not____

12) Do you deem the individual to be compliant in taking medication?

   □ Yes □ No, please explain____

13) **Documented** maximum distance applicant is able to travel? (a Kokomo downtown city block is approximately 300 feet).

________300 feet ________600 feet ________900 feet ________1000 feet

________1500 feet ________2000 feet ________ if farther, how many feet?

Please, (in detail) explain limitations on distance (how/why does the disability limit the applicant's functional ability?): ____

____

14) Are any of the following **documented** as a result of the individual's disability? (Check all that apply and **provide supporting documentation for each**)

_______ Disorientation
_______ Problem solving
_______ Short-term memory
_______ Long-term memory
_______ Gait or balance
_______ Inappropriate behavior
_______ Inability to step up or down
_______ Monitoring time
_______ Judgement
_______ Communication
_______ Inconsistent performance
_______ Inability to navigate terrain
_______ Inability to follow directions
_______ Inability to cross the street

Please send written, detailed explanation or attach supporting documentation for disability that inhibits the applicant's functional ability to use the fixed route system

(we **MUST** show the applicant does not have the ability to use the fixed route system. It cannot just be more difficult, uncomfortable, or inconvenient).

15) Would mobility training be appropriate for this individual?

□ Yes, suggested training? ____

□ No, why not? ____

16) Would training tools be helpful with fixed route travel (e.g., memory cards, written route directions, photos, etc.)?

□ Yes, which tools? ____

□ No, why not? ____

17) What functional ability limitations does this individual have that makes them unable to use the City-Line Trolley fixed route ____

____

18) Are they able to use the fixed route system under any condition/circumstance (e.g., favorable weather, shortened distance to walk, accessible sidewalks, etc.)? _________________________

____

SPECIFIC: Please Complete Only if Applicable to Applicant

Blind /Visually Impaired

Is the individual? ________ Totally blind _________ Legally blind

Does the individual use: ________ Long White Cane _________ Service Animal

To your knowledge, has the individual had orientation and mobility instruction to enable him/her to get around the community independently? ________ Yes ________ No ________ Unknown

Visual Acuity with Best Correction: Right Eye ________ Left Eye: ________ Both Eyes ________

Visual Fields: Right Eye _______ Left Eye ________

Deaf /Hearing Impaired

Is the individual? ______ Totally Deaf ______ Hearing Impaired

When communicating with hearing people, does he/she use:

______ American Sign Language _______ Lip Reading _______ Note Writing

______ Unknown

For the Cognitively Impaired

I.Q. scores ____

Adaptive Behavior score____

Date of onset: _______/_______/_______ Date of testing: _______/_______/_______
Month Day Year Month Day Year

Is the applicant able to:

Give address and telephone numbers upon request?

☐ Yes ☐ No

Recognizes a destination or landmark?

☐ Yes ☐ No

Deal with unexpected situations or unexpected change in routine?

☐ Yes ☐ No

Professional Title (check one or more)**:**

□ Licensed physician
□ Licensed physical therapist
□ Certified rehabilitation specialist
□ Licensed social worker
□ Licensed optometrist
□ Certified Audiologist
□ Certified psychologist
□ Nurse (LPN or RN)
□ Registered occupational therapist
□ Certified speech pathologist
□ Other please describe____

I hereby certify that all information submitted on this form is true and meets federal reporting standards to the best of my knowledge.

____
Signature / Date

____
Print Name

____
Street Address

____
City / State / Zip

(______) ______________________________
Telephone Number

(______) ________________________________
Providers Fax Number

____
Email

____
License/Certification Number

____
State

THANK YOU FOR YOUR ASSISTANCE!

Please return this application to the person seeking ADA certification, or if application is completed, you can **MAIL, E-MAIL OR FAX TO:**

The Spirit of Kokomo
219 E. Sycamore St.
Kokomo, IN 46901

E-mail: Transportation@cityofkokomo.org
Fax: 765-456-7239