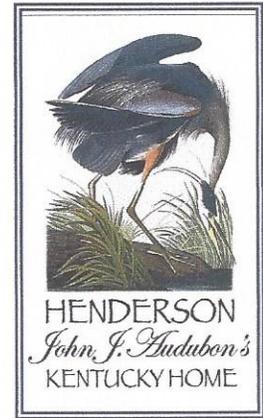




The City of Henderson

P.O. Box 716
Henderson, Kentucky 42419-0716



Mass Transit Department

Phone: 270-831-1249

Fax: 270-831-1253

E-Mail: bjwethington@cityofhendersonky.org

ADA APPLICATION FOR DEMAND RESPONSE SERVICE

The American with disabilities Act of 1990 (ADA) is a civil rights bill, which bans discrimination against people with disabilities. To meet their needs, public transit systems must provide a variety of services.

If you have a disability, which prevents you from using a HART bus some or all of the time, you may be eligible for ADA Demand Response service some or all of the time.

All information will be kept confidential. Only the information required to provide the service you request will be disclosed to those who perform those services. Your answers will not be shared with any other person or company.

WHO QUALIFIES: Under the ADA regulations, there are two categories of persons who are eligible for ADA paratransit.

Any individual with a disability qualifies who:

1. Is unable, as the result of a physical or mental impairment, to get on, ride, or get off an accessible vehicle on the public transit system; or
2. Has a specific impairment-related condition (including vision, hearing or impairments causing disorientation), which prevents travel to or from a bus stop on the system.

It is important that all parts of this form are completed. If the application is not complete, it will be returned to you and that will delay having your application processed.

Please use the envelope provided or return to:

City of Henderson
Mass Transit Dept.
P.O. Box 716
Henderson, KY 42419-0716

If you have questions, please call 270-831-1249

TDD*: 270-831-1249



PLEASE PRINT

Last Name _____ First _____ Middle _____

Address _____

City _____ State _____ Zip _____

Date of Birth (month/day/year) _____/_____/_____

Daytime Phone _____ Evening Phone _____

Language Ability: _____ English _____ Other (specify) _____

Emergency Contact Name _____

Relationship _____

Daytime Phone _____ Evening Phone _____

TDD _____
(Telecommunication Device for the Deaf)

A. MOBILITY INFORMATION

1. Which of these mobility aids or equipment do you use to help you get where you need to go?
(Check all that apply)

- | | |
|-----------------------|---------------------------|
| _____ None | _____ White Cane |
| _____ Cane | _____ Manual wheelchair |
| _____ Scooter | _____ Electric wheelchair |
| _____ Walker | _____ Service animal |
| _____ Crutches | _____ Picture Board |
| _____ Portable oxygen | _____ Other _____ |

2. Is your health condition or disability temporary?

Yes No

3. If temporary how long do you expect to need our services? _____

4. For individuals who do not use mobility aids, how many city blocks can you walk independently?

0-1 2-3 4 or more

5. If you use mobility aids, how many city blocks can you travel independently?

0-1 2-3 4 or more

6. Can you climb three 12-inch steps without assistance?

Yes No

7. How far is the nearest bus stop (in city blocks) from your residence?

0-1 2-3 4 or more

8. If you were eligible for paratransit van service, will you:

Be able to meet the van at the curb

Need driver assistance

B. INFORMATION ON HEALTH CONDITION OR DISABILITY

General Medical Condition

None

Kidney Failure

Cancer

Organ Transplant

Diabetes

Other (list) _____

Bone and Joint Condition

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fusion | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Osteo-arthritis | <input type="checkbox"/> Broken Bone:
Specify _____ |
| <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Amputation of:
Specify _____ |
| <input type="checkbox"/> Other _____ | |

Brain / Nerves / Muscle Condition

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Vertigo / Dizziness |
| <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Brain Injury |
| <input type="checkbox"/> Guillian-Barre | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Post-polio |
| <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Other _____ | |

Heart and Circulatory Condition

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Peripheral Vasculas Disease | <input type="checkbox"/> Angina |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Other _____ | |

Lung and Breathing Condition

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Chronic Obstruction Pulmonary Disease (COPD) | |

Vision / Hearing / Speech Condition

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Aphasia |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hard of Hearing |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Legally blind |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Diabetic Retinopathy |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Partially Sighted |
| <input type="checkbox"/> Deaf Blind | <input type="checkbox"/> Visual Field Deficit |
| <input type="checkbox"/> Other _____ | |

Developmental / Mental Condition

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Dwarfism |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Thought Disorder | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

APPLICANT SIGNATURE

I certify that the information I gave in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential, and only the information required in provide the service I request would be disclosed to those who perform those services.

Applicant signature _____

Date ___/___/___

Person completing form other than applicant (please check one)

____ I certify that the information provided in this application is true and correct based upon information given to me by applicant.

____ I certify that the information provided in this application in this application is true based upon my knowledge of the applicant's health condition or disability.

Exceptions or Additions _____

Print Name _____

Signature _____ Phone _____

Relationship to Applicant _____ Date _____

Address _____

City _____ State _____ Zip Code _____