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: cmwindhaus@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 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_____EveningPhone_____

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 _____Manuel 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

_____None

_____Ankylosing Spondylitis

_____Fusion

_____Osteo-arthritis

_____Scleroderma

_____Other_____

_____Rheumatoid Arthritis

_____Arthritis

_____Osteoporosis

_____Broken Bone:
Specify_____

_____Amputation of:
Specify_____

Brain / Nerves / Muscle Condition

_____None

_____Huntington's Chorea

_____Muscular Dystrophy

_____Hemiplegia

_____Guillian-Barre

_____Quadriplegia

_____Paraplegia

_____Dementia

_____Other_____

_____Alzheimer's Disease

_____Parkinson's Disease

_____Vertigo / Dizziness

_____Brain Injury

_____Spina Bifida

_____Post-polio

_____Stroke

____Epilepsy

Heart and Circulatory Condition

_____None _____Congestive Heart Failure

_____Peripheral Vasculas Disease _____Angina

_____High Blood Pressure _____Heart Attack

_____Edema _____Heart Surgery

_____Other_____

Lung and Breathing Condition

_____None _____Allergies

_____Lung Cancer _____Emphysema

_____Asthma _____Cystic Fibrosis

_____Chronic Obstruction Pulmonary Disease (COPD)

Vision / Hearing / Speech Condition

_____None _____Aphasia

_____Glaucoma _____Hard of Hearing

_____Cataracts _____Legally blind

_____Deaf _____Diabetic Retinopathy

_____Night Blindness _____Partially Sighted

_____Deaf Blind _____Visual Field Deficit

_____Other_____

Developmental / Mental Condition

_____None _____Dwarfism

_____Autism _____Psychosis

_____Thought Disorder _____Mood Disorder

_____Developmental Disability _____Mental Retardation
___Yes ___No ___Yes ___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___/___/___

In order for the City of Henderson to evaluate your request for ADA eligibility certification, it may be necessary to contact a health care or rehabilitation professional for additional information about your disability and ability to use regular fixed route service. Please complete and sign the following authorization.

Note: It is important that, you identify a professional who is familiar not only with your particular disability but who understands your ability or inability to travel on the public transit system. This could include:

- Rehabilitation specialist
- Mental health counselor
- Physician or registered nurse
- Independent living counselor
- Occupational or physical therapist
- Vocational rehabilitation counselor
- Social worker
- Psychologist

I authorize the following professional to release to the City of Henderson information about my disability and its affect on my ability to travel, which may be needed in connection with my request for ADA paratransit eligibility certification. It is my understanding that the information released will be used solely to determine my ADA paratransit eligibility. I understand that I may revoke this authorization at any time. Unless earlier revoked, this form will permit the professional listed to release the information described until 90 days after the date appearing below

Name of Professional_____

StreetAddress_____

City_____ State_____ Zip code_____

Telephone Number (____)_____

Applicant's Name_____
(PLEASE PRINT)
Applicant's 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_____