

County of Kauai
TRANSPORTATION AGENCY

Application
For
ADA Paratransit Service

Instruction:

1. Fill out Transportation Paratransit Service Application.
2. **Please have a Medical Professional (which may include physicians familiar with your disability) complete and sign the Verification of Paratransit Eligibility which is on the last page.**
3. Take or mail the completed application to:

County of Kauai
Transportation Agency
3220 Hoolako Street
Lihue, HI 96766
4. Please make sure your application is complete and all questions are answered. Incomplete applications will be returned and not processed until completed.
5. The Transportation Agency will review your application and follow up as necessary to determine your eligibility for ADA service.
6. You will be notified in writing as to your eligibility status.
7. If you have not heard about your eligibility status within 21 days of submitting your application, call (808) 246-8110. If a determination has not been made yet, you will be temporarily eligible.
8. If you are denied eligibility, you have a right to appeal the eligibility decision. Please contact the Transportation Agency for details on the appeals process.

County of Kauai
TRANSPORTATION AGENCY
Paratransit (Door-to-Door) Service Application

Check all that apply:

Senior Male
 Agency Female
 ADA Senior Center Member

DATE: _____

Name: _____
Last First Middle Initial

Birth Date: _____ **Phone:** _____ **Email Address:** _____

Mailing Address: _____
P.O. Box or Street Town State Zip-Code

Residence Address: _____
Street Town

Directions to Home _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Mobility Status: (Please check all that apply)

Walk-on Uses Cane Uses Walker Uses Crutches Need to use lift instead of steps
 Manual Wheelchair **Length:** _____ **Width:** _____ Requires Portable Oxygen
 Motorized Wheelchair **Length:** _____ **Width:** _____ Requires Personal Care Attendant
 3-Wheel Scooter **Length:** _____ **Width:** _____ Other: _____

Common wheelchair/scooter size limits: 53" in length and 33" in width and 800 pounds when occupied.

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR STATISTICAL PURPOSES:

Ethnic Group (Check One)

African American American Indian/Alaskan Native Japanese, Filipino Korean
 Hawaiian/Part Hawaiian Hispanic/Latino Chinese Vietnamese Other Asian/Pacific Islander
 Samoan White Choose Not To Declare

Household Size (Check One)

Live Alone With Spouse With Relatives With Non-relatives Care Home
 Other _____ Choose Not To Declare

Personal Income: \$ _____ Per Month _____ Choose Not To Declare

I hereby authorize the release of information and photos relating to transportation services for statistical purposes.

Signature

Name of Person Other Than Applicant Completing Form

Date

Relationship

Phone

Return completed form to: County of Kauai, Transportation Agency, 3220 Hoolako Street, Lihue, HI 96766

Eligibility

ADA services are provided for persons with disabilities unable to use fixed route services if they meet one or more of the criteria listed below.

Please check all that apply:

_____ **Category 1**

I have a physical, mental or visual disability or impairment which prevents me from using the Kauai Bus without an attendant for:

a. ___ Boarding/Disembarking

b. ___ Identifying the correct bus

c. ___ Riding (If you check here, check one of the following also)

_____ I am unable to handle/grasp coins (pay fare), railings, handles

_____ I am unable to keep balance while seated on a moving vehicle

_____ I am unable to read, hear, understand and/or process information which are needed to make necessary decisions during a trip

d. Other (Describe) _____

_____ **Category 2**

I can use the Kauai Bus with wheelchair lift but:

a. ___ The wheelchair lift cannot be deployed at my stops(s).

List location(s): _____

b. ___ My wheelchair cannot be accommodated on the Kauai Bus.

Explain (type, size, securement devices, dimensions, weight of wheelchair, etc.): _____

_____ **Category 3**

I can use accessible buses but have an impairment-related condition, which prevents me from traveling to and/or from a bus stop.

- a. ___ I am unable to travel to the nearest bus stop.
If you checked "a", you need to complete "b" also.
- b. ___ I am able to travel _____ blocks on my own or using my mobility aid (1 block equals 500 feet).
- c. ___ I am unable to wait at the bus stop.
- d. ___ I am prevented from traveling to or from a boarding location for the following reasons:

- ___ Inability to negotiate hilly terrain
 - ___ Extreme sensitivity to climatic conditions
 - ___ Allergic/environmental sensitivities
 - ___ Hyper-fatigue, frailty
 - ___ Night-blindness
 - ___ Inability to cross busy intersections
 - ___ Other (Describe)
-

APPLICANT INFORMATION

1. **Describe your disability and explain in detail how it prevents you from using The Kauai Bus service some of the time or all of the time.** Be specific. Attach additional sheets, if necessary.

2. **My condition is:**

_____ Permanent _____ Temporary _____
(Expected Duration)

3. **Do you require a Personal Care Attendant (PCA) to accompany you when you travel on the Kauai Bus?**

If you check **Yes**, you will not be transported without your PCA.

If you check **Sometimes**, please explain which situations require your PCA

_____ No _____ Yes _____ Sometimes
Explain: _____

If you checked **Yes** or **Sometimes**, please list the name(s) of your PCA:

Name: _____

Address: _____

Telephone: _____

4. **Have you had any training to learn how to use the Kauai Bus?**

_____ No Specify training needs: _____

_____ Yes Training was done at: _____

I hereby certify that the information given in this application is correct.

Signature: _____ Date: _____
Applicant

Print Name of Person Other Than Applicant Completing This Form

_____ Date: _____
Signature of Person Other Than Applicant
Completing This Form

**AUTHORIZATION
FOR
RELEASE OF INFORMATION**

In order for the County of Kauai Transportation Agency to evaluate your application, it is necessary to contact a Health Care Worker or other Professional to verify the information that you have provided.

Please list the name of a Professional (which may include Physicians, Agencies or others familiar with your disability) who may be contacted by the Transportation Agency.

Complete name, mailing address and telephone number is required below:

I hereby authorize:

Name: _____

Mailing Address: _____

Telephone: _____

to release to the County Transportation Agency the information about my disability which will verify my eligibility for ADA services. The information released will be used solely to determine my eligibility for ADA services.

I understand that I have the right to receive a copy of this authorization.

I understand that I may revoke this authorization at any time. Unless revoked, this form will permit the Health Professional who is certifying my disability to release the information described until 60 days after the date appearing below.

Print Name of Applicant

Date Signed

Signature of Applicant

PLEASE NOTE THAT THIS PROFESSIONAL VERIFICATION IS ONE STEP IN DETERMINING AN APPLICANT'S ELIGIBILITY FOR PARATRANSIT SERVICE. FINAL APPROVAL OF ELIGIBILITY IS MADE BY THE COUNTY TRANSPORTATION AGENCY.



**TRANSPORTATION AGENCY
THE COUNTY OF KAUA'I**

**DEREK S. K. KAWAKAMI, MAYOR
MICHAEL A. DAHLIG, MANAGING DIRECTOR**

**CELIA MAHIKOA
EXECUTIVE**

**JEREMY KALAWAI'A LEE
ASSISTANT EXECUTIVE**

MEDICAL PROFESSIONAL VERIFICATION OF PARATRANSIT ELIGIBILITY

Applicant's Name: _____

I have reviewed the enclosed application and agree with the information:

_____ Yes

_____ No

Please explain: _____

I hereby certify the information given on this Verification of Pararansit Eligibility is correct.

Signature

Date

Print Name: _____

Title: _____

Address: _____

Telephone: () _____

Please note that this verification is one step in determining an applicant's eligibility for Paratransit service. Final approval of eligibility is made by the County Transportation Agency.

