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 be transported with 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.
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 Paratransit Eligibility is correct.

___________________________________________

Signature

____________________________________________________________________

____________________________________________________________________

(   ) _____________________________________________________________

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.