SEDGWICK COUNTY TRANSPORTATION (SCT)
2622 W Central Ave, Suite 500
Wichita, KS 67203
(316) 660-5150 Fax: (316) 660-1936
Long Distance: 1-800-367-7298
www.sedgwickcounty.org/aging click link Transportation

Sedgwick County... working for you

All information provided on this application determines eligibility and is used for demographic report purposes. Please complete as much as possible.

SCT Office Usage Only: Client ID____________

Date Rcv'd__________ Date Entered ___________

Program Code(s) ______________/_____________

Applicants Name__________________________________

Address__________________________________

Building__________________________ **Apt. #**__________

City ______________________________ **Zip** ____________

Gender: Male ________ **Female** ________

EMERGENCY CONTACT

Name______________________________

Phone number________________________

Relationship to applicant_________________

Date of Birth _____________________ **Age** __________

Race/Ethnicity _________________________________

Home Phone # ___________________________________

Cell Phone # ___________________________________

Number in household (count applicant as one, spouse, dependent's (children) if under the age of 18 yrs) ________

Gross Monthly Income _$_______________________

Do you currently use other transportation programs? ____No ____Yes (If yes, please circle all that apply.):

Wichita Transit Specialized Paratransit Service Wichita Transit Fixed Route Medicaid (NEMT State Program)

American Red Cross Taxi Cab Other (specify) ____

Please check any of the following that apply to Applicant: _____Use Service Animal ______Visually Impaired

_____Hearing Impaired _____Speech Impaired _____Use Oxygen _____Use Cane/Crutch _____Use Walker

_____Memory Impaired (Circle: Mild Moderate Severe) _____Has an Attendant (***not provided thru program***)

_____Requires assistance from door of residence to door of destination ______Requires assistance beyond threshold of residence and through door of destination (***not provided thru program***; referrals given)

Applicant can step in and out of a minivan? ____Yes ____No **Applicant can step up into a bus**? ____Yes ____No

Please check which mobility device(s) if any that the applicant may use and bring along for transport:

_____Standard non-motorized 4 wheel device (fold-up) _____Over-sized non-motorized 4 wheel device (fold-up)

_____Motorized (Electric) 4 wheel device _____Over-sized motorized 4 wheel device _______ Bicycle

_____Scooter (3/or more wheeled device - specify model/brand)__________________________________

Can Applicant independently transfer in/out of 3 or more wheeled mobility device? _____Yes _____No _____N/A

Is the wheeled mobility device equipped with a lap belt? _____Yes _____No _____Not Applicable
Seat belt usage in vehicle(s) is required during transport.

Does the individual combined with the wheeled mobility device exceed 700 pounds? _____Yes _____No _____Don't Know _____N/A

Does the individual's residence have an accessible mobility ramp? _____Yes _____No _____Not Applicable

****Service is unable to accommodate Same Day or Emergency trips, Geri-Chair or Stretcher devices nor Assisted Living, Home Plus or Nursing Facilities****

Rev. 03/15

SEDGWICK COUNTY TRANSPORTATION
PHYSICAL DISABILITY STATEMENT—TO BE COMPLETED BY A PHYSICAN ONLY

If you are physically disabled, this page is to be completed by your physician. This information is needed in order to better serve you, to confirm your disability, and to qualify you for rides subsidized by Sedgwick County. All information provided will be strictly confidential.

If you do not have a physical disability, or if you reside outside the city of Wichita, this statement does not need to be completed and you may qualify for other subsidized rides.

The following disabilities do not automatically qualify you for the program. If your disability is not listed below your rides do not qualify to be partially subsidized by Physical Disability Mill Levy funds:

WRITE IN'S WILL NOT QUALIFY AS A COVERED DISABILITY.

________ **Restricted mobility:** Disabilities requiring the use of a wheelchair, cane, crutches, leg braces, walker or other orthopedic devices used to assist an individual.

________ **Loss of extremities:** Anatomical deformity or amputation of hands, one hand and one foot, or loss of major function.

________ **Stroke:** Ongoing debilitation effects following occurrence of a stroke.

________ **Cardio-pulmonary disease:** Serious loss of heart or lung reserves; in spite of medical treatment, there is breathlessness, pain or fatigue.

________ **Legally blind:** Severe visual impairment that is bilateral and not correctable with lenses.

________ **Legally deaf:** Hearing impairment that is bilateral and not correctable with a hearing aid.

________ **Epilepsy** (convulsive/grand mal).

________ **Neurological disabilities:** Neurological and physical impairments not controlled by medication (i.e., cerebral palsy or multiple sclerosis). **This category does not include diagnosed mental illnesses.*

________ **Dementia/Alzheimer's** (Circle: Mild Moderate Severe)

Are any of the above disabilities permanent? _______Yes ________No

If no, specify which one(s) and, estimated duration is ________months (this does not include pregnancy).

:____

I hereby certify that the applicant ____ is a person with a disability as defined by the preceding criteria and that the information contained in this form to be true.

____ ________________________________
Physician Name (please print) **Date**

____ ________________________________
Physician Signature **Phone**

____
Address

Rev. 07/11