Sedgwick County... working for you

SEDGWICK COUNTY TRANSPORTATION (SCT)
271 W. 3rd St. N., Suite 500
Wichita, KS 67202
(316) 660-5150 Fax: (316) 660-1936
Long Distance: 1-800-367-7298
www.sedgwickcounty.org/aging click link Transportation

Information provided on this application determines eligibility, helps SCT with understanding of how to best perform individual transport and is used for demographic reporting to our grantees and to seek grants. Please complete as much as possible.

_____
Applicants Legal Name (first, last)

Address_____

Building_____ **Apt. #**_____

City _____ **Zip** _____

SCT Office Usage Only: Client ID_____

Date Rcv'd_____ Date Entered _____

Program Code(s) _____/_____

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 $_____

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 by SCT***)

_____Needs assistance from door of residence to door of destination _____Needs assistance beyond Threshold of residence and through door of destination (***not provided by SCT***; other transport referral will be provided)

Can applicant step up & in to a minivan? ____Yes ____No **Can applicant step up into a bus**? ____Yes ____No

Please check which mobility device(s) if any that the applicant may use and/or 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 800 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 Emergency trips, Geri-Chair or Stretcher devices nor Assisted Living, Home Plus or Nursing Facilities

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

If the individual seeking services has a disability, this page is to be completed by their primary physician and returned via fax (316) 660-1936 from the physician's office. This information aids the program to confirm disability, and potential eligibility for rides subsidized by Sedgwick County. Information will be kept confidential and is used anonymous for reporting purposes.

The following disabilities do not automatically qualify you for the program.

This form is not intended to provide reduced fares, but to identify potential qualifiers of partially funded disability trips.

Alterations to the application will not be accepted.

_____ **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)

_____ **Other:** _____
To be completed **by your primary physician** of diagnosis. Form **may not** be completed by a Physician's Assistant, Nurse, Optometrist, Chiropractor or Podiatrist.

Are any of the above disabilities permanent? _____**Yes** _____**No** **If no,** specify which one(s) and, estimated duration is _____months (disabilities do not include pregnancy).

:_____

I hereby certify that the applicant (first and last name) _____ 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 (printed) **Date** (month/day/year)

_____ _____
Physician Signature **Phone #**

_____
Address (Street, City, State, Zip Code)

Rev. 04/16