



Sedgwick County... working for you

SEDGWICK COUNTY TRANSPORTATION (SCT)
271 W. 3rd St. N., Suite 500 | Wichita, KS 67202

Hotline: (316) 660-5150 Fax: (316) 660-1936
Aging/Disability Resource Call Center: 1-800-367-7298

www.sedgwickcounty.org/aging click link Transportation

Information provided on this form assists SCT with understanding of how to best perform individual transport and is used for granting web scheduling access as well as demographic reporting to our grantees and/or to seek grant opportunities. 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 \$ EMAIL Address:

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) 3 or more wheel device Over-sized Motorized wheeled 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, Stretchers, Segway's or Carts. This is a general public transportation program and there are limitations to what this service is capable of performing.

**SEDGWICK COUNTY TRANSPORTATION
DISABILITY STATEMENT—TO BE COMPLETED BY A PHYSICIAN 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)