

Check If Renewal _____

Date Received _____
Date Processed _____
Date Approved _____
Date Denied _____

OFFICE USE ONLY
Sponsor / PCA / WC _____

Date Notified _____
Client Status Code _____
City Code _____
Computer _____

CARTA BUSES ARE...



CARTA CARE-A-VAN RIDER'S ADA APPLICATION

1. Applicant must have a **DISABILITY** to qualify.
2. You must live **INSIDE** the city limits of Chattanooga or Signal Mountain.
3. If **ALL** Spaces Are Not Completed, Form Will Be Returned.
4. Please **Read Entire Application** and **Print Neatly** or **Type**.
5. Only **ONE** Person Per Application.
6. **DO NOT** Attach Transportation Requests or Schedules.
7. Application May Require **21 Days** Processing Time.

This Application Can Be Made Available In Accessible Form.
If You Need Assistance Completing Form, Please Call 698-9038

PERSONAL INFORMATION

Date of Application: _____ Soc. Sec. # _____
 Print Name: _____ Male _____ Female _____
Last First
 Address: _____ Apt. No.: _____
 City / State: _____ Zip: _____
 Telephone : Home: _____ Work: _____
 Birth Date: ____ / ____ / ____ Email Address: _____

**** EMERGENCY CONTACT – (Application will be Returned If Left Blank) ****

<u>Name</u>	<u>Address</u>	<u>Phone #</u>	<u>Relationship</u>
_____	_____	_____	_____

Disability That Prevents You From Using CARTA Bus Service
Answer ALL of the following questions in this box-----Do Not Leave Blank

1. List your specify Diagnosis: Disability/Illness AND check any applicable items below:

(example - Heart, Cancer, Diabetes - do not use initials! **ANSWER HERE** → _____)

- a. Visually Impaired- Total: _____ Partial: _____ Vision: Right – 20/ _____ Left – 20/ _____
- b. Hearing Impaired _____
- c. Mentally Impaired _____
- d. Wheelchair user - Powered _____ Manual _____ Scooter _____
- e. Crutches: _____ Braces: _____ Walker: _____ Prosthesis: _____ Other: _____
- f. Other mobility limitations or physical impairments – please describe: _____

Is this condition temporary? Yes _____ No _____ If yes, expected duration until: _____

Client's Initials: _____

2. THE FOLLOWING INFORMATION WILL BE USED TO ENSURE THAT AN APPROPRIATE VEHICLE IS UTILIZED TO PROVIDE YOUR TRANSPORTATION AND THAT AN ACCURATE ANALYSIS OF YOUR TRIP REQUESTS CAN BE MADE.

a. Do you use any of the following aids to mobility? (Answer All Yes or No) - Do not leave blank.

Wheelchair _____ If Your Wheelchair Is Larger Than Standard Wheelchair (30 Inches Wide - 48 Inches Long - 200+ Lbs.) Please Describe: _____

Powered scooter _____ Scooters are not recommended for safe transportation.
If you use a scooter, can you transfer to a seat? Yes _____ No _____

Other Assistive Mobility Devices (describe) _____

Service Animal Yes _____ No _____ Alphabet Board Yes _____ No _____

Oxygen Tank Yes _____ No _____ Does your house have a ramp? Yes _____ No _____

3. Do you require someone to assist you when you travel using transit? (It is Client's responsibility to provide assistant.) Driver is only responsible to provide assistance from curb to vehicle. No fare is charged for assistant to ride with you. (DO NOT LEAVE BLANK**)**

(Do not leave blank) YES _____ NO _____

4. Please answer ALL of the following questions:

If you answer No to #1 you must bring someone to assist you. Do not leave blank.

a. Can you walk 200 feet - **OR - push or maneuver your wheelchair 200 feet without the assistance of another person?**

Yes _____ No _____ Sometimes _____

b. Can you walk 1/4 -mile - **OR - push or maneuver your wheelchair 1/4 mile without the assistance of another person?**

Yes _____ No _____ Sometimes _____

c. Can you walk three-quarters of a mile - **OR - push or maneuver your wheelchair three-quarters of a mile without the assistance of another person?**

Yes _____ No _____ Sometimes _____

d. Can you climb three 8-inch steps without assistance?

Yes _____ No _____ Sometimes _____

e. Can you wait outside without support for ten minutes?

Yes _____ No _____ Sometimes _____

Client's Initials: _____

5. Explain how your disabilities prevent you from using a regular CARTA bus? Please explain completely. Use an additional sheet if needed. Do not leave blank.

6. Are there any other illnesses, disabilities, or effects of your disability, which we need to be aware? (I.e., Seizures, Heart Problems, Blood Pressure, etc. . . .) Please write out - do not use initials for disabilities or diagnosis. Do not leave blank.

7. Do not leave blank or form will be returned.

Who will be responsible for payment? Cash _____ Self Bill _____ Other _____ Agency _____

Name and Billing Address of Agency or Other _____

8. PLEASE NOTE: In cooperation with Governmental Emergency Management Services, the information supplied in this ADA application may be shared in order to provide emergency services to our transit clients in case of a national emergency and/or natural disaster.

I/We have received and read the CARTA Care-A-Van Client Policies. I/We understand each policy and agree to abide by them.

I/We certify, to the best of my/our knowledge, the above information is true and correct. I/We understand that if I/We have submitted any false information, any ADA eligibility status will be revoked immediately.

(Do not leave blank or application will be returned unapproved.)

Date

Must contain signature of Applicant, Guardian, or Agency completing application or requesting transportation.

9. To Be Filled Out BY APPLICANT - NOT Physician

Medical Authorization Release
(Application Will Be Returned If Left Blank)

In order to allow your request to be evaluated, it may be necessary for us to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form. This authorization will remain in effect for the duration of approved eligibility.

The following (check one):

Physician _____ Health Care Professional _____ Rehabilitation Professional _____
is familiar with my disability and is authorized to provide information required.

Physician's Name: _____

Physician's Address: _____

(City / State / Zip): _____

Physician's Telephone: _____

I, _____ do hereby authorize
(Print Patient Name)

The Chattanooga Area Regional Transportation Authority (CARTA), or its representatives, to obtain copies of any and all medical records pertaining to my health condition from any health care provider.

Patient Signature (Guardian or Agency if Client is unable to sign) **Date**
Must be signed or application will be returned unapproved.

10. If this application has been completed by someone other than the person requesting certification, that person MUST FULLY COMPLETE the following:

Name: _____ Agency: _____

Address: _____

(City / State / Zip): _____

Phone: _____ Fax Number: _____

Signed: _____ Date: _____

Please Return Application to:

CARTA CARE-A-VAN
1617 Wilcox Boulevard
Chattanooga, TN 37406

Contact CARE-A-VAN:
(423) 698-9038 – Telephone
(423) 698-8555 – Fax
(423) 698-8418 – TDD
Web Site: <http://www.carta-bus.org> – follow link to Care-A-Van page.

Siskin Hospital has a Travel Trainer on staff, for further information please contact: Ms. Valerie Powell; One Siskin Plaza; Chattanooga, TN 37403. Phone: 423/634-1576; Fax: 423/634-1491.