Flint Hills Area Transportation Agency
5815 Marlatt Avenue
MANHATTAN, KS 66503
785-537-6345 FAX: 785-537-6327
Email: fhata@fhata.org

The Flint Hills aTa Bus provides an origin to destination para-transit service to individuals who cannot use Flint Hills aTa Bus Fixed Route services to make their trips. To be eligible for this service, the functional limitations of an individual's disability must prevent regular use of Flint Hills aTa Bus Fixed Route service. Architectural and environmental barriers such as distance, terrain or weather do not, alone, form a basis for eligibility. However, consideration may be given to the interaction of environmental conditions (terrain and weather) with the individual's impairment-related condition. **Disability alone does not automatically qualify an individual for origin to destination bus service**

ADA Paratransit

The Americans with Disabilities Act (ADA) complementary paratransit services are available for customers who are unable to use fixed-route services due to their disability. This service is offered in Manhattan and Junction City Kansas. Federal regulations define the service area as being within ¾ mile of a local fixed route when that route is in operation.

Non-ADA Paratransit

If you are over 60 and/or have a disability, non-ADA paratransit services are available. Non-ADA Paratransit services are offered in Manhattan and Junction City, Kansas

Email or Mail Completed Applications, proof of age (if applicable), professional/medical form (if applicable) **AND A COLOR PHOTO** to be used for an ID card (we must be able to see your face only in the photo):

Send completed applications and accompanying photo to:

Email: fhata@fhata.org

Mail: FHATA
5815 Marlatt Ave
Manhattan, KS 66503

Reminders:

- If more information is required, you will be contacted.
- Incomplete applications delay processing (color photo is needed to be complete).
- Processing may take up to 21 business days from receipt of a complete application.

Please be sure to check this list before you submit your application:

- ☐ Did you complete the application?
- ☐ Did you remember to sign the form?
- ☐ Is a clear color photo is attached
- ☐ Is my medical form completed (needed for ADA paratransit)
- ☐ Customers applying based on age, please provide proof of age (NO ORIGINALS – copy of ID, birth certificate, etc.)

Disclaimer: Completing this application does not automatically certify you for paratransit services. Some applicants may be required to go through a phone interview and/or functional assessment to assist in determining your level of eligibility. ***All applicants will be notified by mail of the outcome of their application.*** *Processing may take up to 21 days from receipt of a completed application, to include completion of a phone interview and/or functional assessment, if required. You will be notified if either is required – you do not need to call.*

Office Use Only: Date Received:___/____/_____ Date Processed:___/____/_____
Client ID:_____ New____Recert _____
Processed by: _____

APPLICATION: Section 1 – General Information & Signature

First Name:_____ Middle Initial:_____ Last Name: _____

Date of Birth:____/____/_____

Gender: ☐ Male ☐ Female

Veteran Status: ☐ Veteran ☐ Not a Veteran

Medicare: ☐ Yes ☐ No Medicaid: ☐ Yes ☐ No

Home Address

Street Number & Name: _____

City State & Zip Code: _____

Name of Complex/Facility/Apartment #: _____

Instructions Needed: _____

Phone Number _____

Email _____

Emergency Contact Information

_____ _____

Name – Relationship to customer Phone Number

_____ _____

Name – Relationship to customer Phone Number

Ethnicity: Please check the most appropriate choice

☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hispanic or Latino

☐ Native American or Pacific Islander ☐ White

☐ Other ☐ Prefer not to say

Primary Language: _____

APPLICATION: Section 2 – Personal & Mobility Information

How do you currently travel to your destinations?

☐ Drive yourself ☐ Family/Friend/PCA ☐ Bus ☐ Taxi/Uber/Lyft

☐ Other *(please specify)* _____

Can you get to and from the bus or streetcar stop nearest your home, by yourself? ☐ Yes ☐ No

If not, please explain: _____

Please describe the disability or health condition that prevents you from using the fixed route bus and/or streetcar system:

If this is a temporary disability or health condition, how long do you expect to need paratransit services?

_____

Please check all that apply to you:

☐ White Cane ☐ 3 Wheel Scooter/Cart ☐ Leg Brace ☐ Support Cane

☐ Walker ☐ Service Animal ☐ Manual Wheelchair ☐ Crutches

☐ Portable Oxygen ☐ Power Wheelchair ☐ Prosthesis ☐ Do Not Leave Unattended

☐ Other *(please specify)* _____

If your mobility device is customized or differently sized, please include any specifications, notes and weight needed in order for us to successfully determine the correct vehicle type

_____

Section 37.3 of the DOT regulations implementing the Americans with Disabilities Act of 1990 (ADA) (49 CFR Parts 27, 37, and 38) defines a "wheelchair" as a mobility aid belonging to any class of three- or more-wheeled devices, usable indoors, designed or modified for and used by individuals with mobility impairments, whether operated manually or powered. FHATA is not required to transport any mobility device that exceeds the weight capacity and or dimensional capacities of the lift. The measurement of the lift platform is 34"x48" with a maximum lift capacity of 800 pounds.

If you checked "Do Not Leave Unattended" above, please explain: _____

Please note: If you require a personal care assistant (PCA), they will need to travel with you at all times. Drivers are unable to assist with anything outside of securing mobility devices, and to and from a door when needed. They are unable to perform duties such as carry bags, assist into a medical facility, etc.

Without the assistance of someone else, please check all the following that you can do:

Board a bus	☐ Yes ☐ No	Read/understand directions	☐ Yes ☐ No
Handle coins and transfers	☐ Yes ☐ No	Travel on a sidewalk	☐ Yes ☐ No
Travel to nearest bus stop	☐ Yes ☐ No	Stand at a bus stop	☐ Yes ☐ No
Identify correct bus	☐ Yes ☐ No	Walk 1/2 a mile	☐ Yes ☐ No
Climb a step or stair	☐ Yes ☐ No	Cross a street	☐ Yes ☐ No
Balance while seated	☐ Yes ☐ No	Grip handles and railings	☐ Yes ☐ No
Give address and phone number	☐ Yes ☐ No	Recognize landmarks	☐ Yes ☐ No
Wait outside for more than 15 minutes	☐ Yes ☐ No	Travel through crowds	☐ Yes ☐ No

Certification of Information & Signature

I understand the information provided on this application is true and correct to the best of my knowledge. The purpose of this application is to determine if I am eligible to use these services. I understand falsification of information could result in loss of paratransit services as well as penalty under law.

Should I qualify for services, I authorize the transit agency and its operating partners to contact me or my emergency contacts for any trip-related communications.

I agree to notify FHATA within 10 days if there is any change in my circumstances (including a change in my mobility device) or if I no longer need to use the transportation services.

Applicant Signature: _____

If this application has been completed by someone other than the person requesting certification, the person completing the application must provide the following:

Name: _____

_____ _____

Preparer's Signature | Relationship to Applicant

FHATA Half Fare Program

Individuals who qualify for the FHATA half fare program are entitled to ride regular fixed route buses for one-half the regular fare. A special half-fare ID card will be issued to eligible individuals who have qualified for the service by completing this application and checking YES in the box below. The half fare program is available for individuals who are 60 years of age and older, low-income individuals and individuals with disabilities. Medicaid cards and State of Kansas medical cards including Medicare are verification of eligibility.

Would you like to apply for the half fare program?

☐ Yes ☐ No

Important Information

If you are applying for an age only application, you are finished and can follow instructions on submission PROOF of Age and a color photo.

If you have a disability and are applying for ADA transportation services, please proceed to Application Section 3, and read instructions on Application Section 4. You will also need a color photo with your completed application.

APPLICATION: Section 3 – Applicant's Release for Information

I understand that the purpose of this evaluation form is to determine my eligibility for ADA service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby authorize my medical representative to release all information regarding my medical condition to FHATA as it applies to this evaluation.

Signature of Applicant	Date
Signature of Preparer (if other than applicant)	Date
Preparer Print Name	Relationship to Applicant

(We suggest you send Application Section 3, along with Application Section 4, to your licensed professional)

APPLICATION: Section 4 – Professional / Medical Form

The applicant has requested eligibility for FHATA paratransit, which is an origin to destination service for people whose disabilities or health conditions prevent them from riding the fixed route buses all or part of the time. Eligibility is not based on medical diagnosis, age, inconvenience, or income. Note all fixed route buses are equipped with ADA-accessible features, such as, lifts/ramps, audio announcements, designated priority seating areas for people with disabilities, enhanced signage, and handrails.

As the applicant's healthcare provider or case manager, you are uniquely qualified to clarify the applicant's functional abilities and limitations to ride the bus, and the information you provide will assist in determining your patient's need to use paratransit for some or all of their transportation needs. All information on this form will be strictly confidential and will not be released. If you have any questions about this form or the FHATA program, please call our team at 785-537-6345, or email fhata@fhata.org.

The information you provide must be based solely upon the applicant having an actual physical or mental impairment that substantially limits one or more major life activities. Thank you for your valuable feedback:

Applicant Name _____ Date of Birth _____

What is the applicant's disability or condition and how does it prevent them from using the FHATA fixed route bus services?

Please check all that apply to the applicant:

☐ Cognitive Impairment ☐ Hearing ☐ Visual ☐ Neurological

☐ Uncontrolled Fatigue ☐ Emotional

☐ Other *(please explain)* _____

Is the applicant's disability or condition permanent or temporary? _____

If temporary, what is the duration? _____

Are any of the following affected by the individual's disability (check all the apply):

☐ Orientation ☐ Monitoring time ☐ Gait or balance ☐ Problem solving

☐ Judgment ☐ Short term memory ☐ Long term memory ☐ Communication

☐ Do not leave unattended in vehicle** ☐ Inappropriate social behavior**

**Please explain if applicant can't be left unattended in a vehicle or conditions of inappropriate social behaviors:

If applicant is currently taking prescribed medication(s), does this medication enhance or diminish the individual's functional ability to travel independently? ☐ Yes ☐ No

If yes, please explain: _____

Certification of Professional/Medical Form

I, the undersigned, certify the medical information provided on the ADA Application is true and correct. I understand providing false or misleading information constitutes fraud and may cause the applicant to have transportation eligibility, if designated, to be revoked.

Licensed Professional Signature

License Number

Licensed Professional Name (Print legibly)

Date

Contact Phone Number

Contact email