



RideKC Freedom is a complementary paratransit program that provides ADA and non-ADA paratransit services throughout the Kansas City region. Paratransit service is an origin to destination, shared ride, advanced reservation public transportation service. When applying for these services, be sure to complete the entire application.

ADA Complementary Paratransit

The Americans with Disabilities Act (ADA) complementary paratransit services are available for customers who are unable to use RideKC fixed route bus and streetcar services due to their disability. Concerns such as diagnosis, age, distance to bus stop, lack of bus service, overcrowded vehicles, inability to drive, personal finances, inconvenience and/or discomfort are not the sole basis of the eligibility determination for paratransit services.

Non-ADA Demand Response Service

Non-ADA demand response services are offered in KCMO, KCKS, Independence and Johnson County. Each area has its own residence requirement, service area and pricing. That information is provided within a ride guide. Below are some of the general guidelines:

- KCMO, KCKS, and Independence - If you are 65 or older and/or have a disability AND live in Kansas City, MO or Kansas City, KS, you may be eligible for non-ADA service in these areas.
- Johnson County, KS - If you are 65 or older, have a disability and/or qualify for low-income assistance AND live in Johnson County, KS, you may be eligible for Johnson County Transit's Special Edition services.

The information obtained in this application will be used to determine your eligibility using the standards established by the ADA and other programs.

Questions? Call 816-842-9070 and press the Eligibility option or email eligibility@kcata.org

How to Apply for Paratransit Services:

1. Review the eligibility information on this application
2. If you have a disability and believe you qualify:
 - a. Complete Part A of the application
 - b. Have a medical professional familiar with your health condition or disability and your functional abilities and limitations complete Part B of the application.
 - c. **When you have both sections completed, call the Eligibility Office at 816-842-9070 to schedule an in-person mobility interview****
3. If you qualify based on your age (referenced on page 1):
 - a. Complete the first page of Section A.
 - b. **Proof of age and a color photo must be included to qualify and obtain a photo ID.**
 - c. You can submit your non-ADA application using one of the following methods:
 - d. Mail the application, your proof of age and your color photo to: RideKC Freedom Eligibility, 1200 E. 18th Street, Kansas City, MO 64108
 - e. Email the application, your proof of age and your color photo to: eligibility@kcata.org.
 - f. **Proof of age and a color photo must be included to qualify and obtain a photo ID.**

No in-person mobility interview is required for applications based on age.

Incomplete applications will delay processing.

****What Happens at My In-Person Mobility Interview:**

1. Bring your completed application (Part A and B) and a photo ID with you to your in-person mobility interview.
2. At your mobility interview, you will meet with a Mobility Specialist and answer questions regarding your disability and how it affects your ability to ride the fixed route system.

You will be notified by letter of your eligibility for the service that you are applying for within 21 days of the completed process. If you have applied for ADA service and have not heard from us in 21 days, please call and we will provide you with service until your determination is made.

If you are denied unconditional ADA paratransit eligibility, you have the right to appeal. Information relating to the appeal process will be included with your letter.

Questions? Call 816-842-9070 and press the Eligibility option or email eligibility@kcata.org.

This application is available in alternate formats. If you would like assistance, please call 816-842-9070.

Part A: Applicant Information and Release

New Application

Recertification

If Recertification, Customer ID Number: _____

Name: _____

Date of Birth: _____ Last 4 Digits of SSN: _____

Gender: Male Female

Veteran Status I am a Veteran I am not a Veteran

Mailing Address: _____

City/State/Zip: _____

Physical Address: _____

City/State/Zip: _____

Alternate Phone Number: _____

Phone Number: _____

Email Address: _____

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: _____

Note if you need written information sent in an alternate format:

Large Print Electronic Format Other: _____

Please provide the name of a local contact that can be reached in case of an emergency

Name: _____

Phone Number: _____ Relationship: _____

Do you have a disability or health condition that prevents you from using fixed route buses or the streetcar?

No, I am applying based only on my age.

Stop here – you do not need to complete the rest of the application. You must attach a copy of documentation of your age. Return this form and documentation to the address listed on page 2.

Yes, I am applying for Paratransit service.

Please continue – you must complete the entire application.

Disability and Limitation

1. Please describe the disability or health condition which prevents you from using the fixed route bus and streetcar system:

2. Is the disability or health condition temporary?

Yes No

If yes, how long do you expect it to prevent you from using the fixed route bus & streetcar system?

3. Do you ever need to bring someone with you to help you when you travel (a personal care attendant or person attendant)?

Yes No

4. Do you use any of these mobility aids or equipment (check all that apply):

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> White Cane | <input type="checkbox"/> 3 Wheel Scooter/Cart | <input type="checkbox"/> Leg Brace | <input type="checkbox"/> Support Cane |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Portable Oxygen | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Prosthesis | |
| <input type="checkbox"/> Other (please specify): _____ | | | |

5. Are you interested in receiving travel training service to learn how to ride the fixed route bus and streetcar service?

Yes No

Certification

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.

I agree to notify the transit agency should my condition change, if my mobility device has changed or been replaced or if I no longer need paratransit service.

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: _____

Mailing Address: _____

City/State/Zip: _____

Phone Number: _____ Alternate Phone Number: _____

Preparer's Signature: _____ Relationship to Applicant: _____

Authorization for Release Information

I authorize the professional who has completed the healthcare provider certification to release to the eligibility organization information about my disability or health condition and its effect on my ability to travel on the fixed route system. I understand that I may revoke this authorization at any time. I understand that all medical information which is provided about my disability or health condition will be kept strictly confidential.

Applicant's Signature: _____ **Date:** _____

Part B: Healthcare Provider Certification

Your patient has requested eligibility for paratransit service. Paratransit service is a shared ride service for people whose disability or health condition prevents them from riding the fixed route system all or part of the time. As the applicant’s healthcare provider, you are uniquely qualified to clarify his or her functional abilities and limitations to ride the accessible fixed route service. In order to help us determine this applicant’s functional abilities, we require that you complete and certify the following questions. Please detail how the applicant’s disability or health condition impacts their ability to travel independently on the accessible fixed route system. Please be as specific as possible. For questions, please call 816-842-9070.

Applicant’s Name: _____

Name of Health Care Provider: _____

License Number: _____ State Issued: _____

Address: _____

City/State/Zip: _____

Phone: _____

1. Written Diagnosis: _____

2. ICD-9CM Code: _____

3. DSM Code: _____

4. How long have you worked with this applicant: _____

5. Is the disability or health condition: Temporary Permanent

a. If temporary, please give the best estimate of recovery time: _____

b. If permanent, is disability or health condition progressive: Yes No

6. If the applicant has a visual disability, what is their visual acuity in each eye:
Left Eye: _____ Right Eye: _____

7. How does the applicant's disability or health condition impact their ability to travel independently on the accessible fixed route system?

8. To your knowledge, does judgment and inhibition impairment prevent the applicant from independently traveling outside the home or immediate environment?

Yes No

9. To your knowledge, does your client have any short-term or long-term memory problem?

Yes No

10. Would extremes in temperatures affect the applicant's ability to ride the accessible fixed route system?

Yes No

11. In your medical opinion, what other factors related to the applicants disability(ies) affect his/her ability to ride the accessible fixed route system?

I hereby certify that the above information is true and correct.

Signature (*can be electronic*): _____

Date: _____