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 ADA Qualification to qualify.**
2. **You must live INSIDE the city limits of Chattanooga.**
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. If a decision is not made within 21 days, services can be used until a decision is made.**

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

PERSONAL INFORMATION

Date of Application: ________________________

Print Name:____ Male_____Female _____
Last First Middle Initial

Address:____ Apt. No. __________

City / State:____Zip: __________

Telephone: Home:_________________________Work: ___________________________________

Birth Date: _______/_____/________ Email Address: ____________________________

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

Name____________________**Address** ____

Phone #__________________**Relationship** ______________________________________

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:________________

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.

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

- Service Animal Yes No Communication Device 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 on the vehicle. No fare is charged for assistant to ride with you.)

(*Do not leave blank)* **YES** **NO** _____

4. Please answer ALL of the following questions:

If you answer Yes to #3 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 _____

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

Medical documentation may be required.

____

____

____

____

____

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. 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. All medical information will be kept separate from application in a locked file, and only the ADA Coordinator will have access or view. Medical documentation may be required.

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**

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:______________________

Must be signed or application will be returned unapproved.

Please Return Application to:

CARTA CARE-A-VAN
740 E. 12th St.
Chattanooga, TN 37403

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

CARTA has a Travel Trainer on staff, for further information please contact Mrs. Alana Shores
alanashores@gocarta.org **Phone: 423/698-9038**
If you are denied transportation and wish to appeal the decision, you must do so within 60 days from the date of denial. All appeals should be sent to: Lisa Maragnano, Executive Director, 1617 Wilcox Blvd. Chattanooga, TN. 37406
Phone : 423-629-1411