Lextran

200 West Loudon Avenue
Lexington, KY 40508
859-898-0350 • lextran.com

# Applicant Information

This section is to be completed by the applicant, the applicant's caregiver, or another individual familiar with the applicant's disability. Please attach supplement documentation if additional space is required to thoroughly answer all questions.

## CLIENT IDENTIFICATION

| | | | | | |
|---|---|---|---|---|---|
| Are you currently an active rider with Lextran Wheels Paratransit Service? | | | | | |
| ☐ | Yes | ☐ | No | | |
| Has your disability or medical condition changed since your last certification? | | | | | |
| ☐ | Yes | ☐ | No | | |
| If "Yes", please explain: | | | | | |
| Did anyone help you complete this application? | | | | | |
| ☐ | Yes | ☐ | No | | |
| If "Yes", please provide Name: | | | | Phone: | |
| Relationship to Applicant: | | | | Email: | |
| Do you have a power of attorney? | | | | | |
| ☐ | Yes | ☐ | No | | |
| If "Yes", please provide Name: | | | | Phone: | |

## DEMOGRAPHIC INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Last Name: | | First Name: | | Middle Initial: | |
| Mailing Address: | | | | Apt# | |
| City: | | State: | | Zip Code: | |
| Home Address (If different from mailing address) | | | | Apt# | |
| City: | | State: | | Zip Code: | |
| Day Phone: | | Mobile Phone: | | | |
| Evening Phone: | | *By providing a mobile number, you consent to receive text notifications. Standard rates apply.* | | | |
| Date of Birth: | | Email Address: | | | |
| Sex: | | Ethnicity: | | | |
| Preferred Language: | | | | | |
| Preferred Method of Contact: | | | | | |

## EMERGENCY CONTACT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Last Name: | | First Name: | | | |
| Phone #: | | Relationship: | | | |
| Street Address: | | | | Apt# | |
| City: | | State: | | Zip Code: | |

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## SECTION 1: DISABILITY / HEALTH CONDITION INFORMATION

1. What is the primary disability or health condition that prevents you from being able to use Lextran buses? Please be specific.

   Date of diagnosis or onset:

2. Do you have other disabilities or health conditions that limit your ability to use Lextran buses?

   ☐ Yes ☐ No

   If you answered "Yes", please explain.

3. Do the effects of your disability or health condition vary from day to day?

   ☐ Yes ☐ No

   If you answered "Yes", please explain.

4. Is your disability or health condition permanent or temporary?

   ☐ Permanent ☐ Temporary

   If you answered "Temporary", please explain.

## SECTION 2: MOBILITY AIDS

1. Check all mobility equipment you expect to use while traveling:

   ☐ Cane ☐ Leg Braces ☐ Crutches ☐ Walker ☐ White Cane
   ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Service Animal ☐ Scooter ☐ Respirator/Oxygen
   ☐ Other:

2. If you use a wheelchair or a scooter, what is the width and length (in inches)?

   Length in inches: Width in inches:

3. Do you require the assistance of another person during travel or at your destination?

   ☐ Always ☐ Sometimes ☐ Never

   If you answered "Always" or "Sometimes", please explain.

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4. What is the estimated combined weight of you and your wheelchair/scooter?

5. Please provide any other information about your disability or health condition that would help us better understand your travel abilities.

## SECTION 3: TRAVEL TRAINING

Individuals qualified for paratransit services are eligible to ride Lextran fixed-route service at no fee with a special ID called a Yellow Card. While not required, if you would like to obtain this card, please call (859) 244-2030 to confirm your eligibility and get more information. Travel training is available for fixed-route buses only, please indicate during your assessment that you would like to explore that option.

1. Would you be interested in Travel Training to use the fixed-route transportation bus system?

☐ Yes ☐ No

## SECTION 4: CERTIFICATION

I understand that the purpose of this application is to obtain eligibility for Lextran Wheels Paratransit Service.

Applicant Signature Date

Responsible Party Signature if Other Than Applicant Date

*An applicant may also fill out this Application online at www.biokinetix.com/lextran.*

*Please mail to:* *Kort Physical Therapy*
*Attn: Lextran Paratransit*
*1650 Bryan Station Rd, Ste 122*
*Lexington, KY 40505*

*Fax to: (904) 513-9292*

**Effective 3/15/2024*