



Sedgwick County... working for you

SEDGWICK COUNTY TRANSPORTATION
2622 W. Central, Suite 500
Wichita, KS 67203
(316) 660-5150 Fax: (316) 660-1936
Long Distance: 1-800-367-7298
www.sedgwickcounty.org/aging/transportation

Name Assigned# Prgm

Address Date filled out:

Building Apt. # Male Female

City Zip Date of birth Age

EMERGENCY CONTACT
Name
Phone number
Relationship to applicant

Race/ethnicity (optional)

Phone number

Number in household (count self, spouse, dependants only)

Gross Monthly Income

How did you hear about us?

Medicaid?--If yes, please provide your 11-digit beneficiary number

and the Medicaid Plan you are under (circle all that apply): TXIX QMB MKN HW21/TXXI HW19 MN

If you have a case manager or independent living counselor please provide their contact information:

Name Phone number

Please check any of the following that apply: Use service animal

Hearing impaired Visually impaired Speech impaired Use oxygen

Memory impaired Use cane/crutch Use walker Need attendant (not provided)

Can you get in and out of a minivan? Yes No Can you step up into a bus? Yes No

Please check which mobility device(s) if any that you will use during transport:

Standard wheelchair (fold-up) Over-sized standard wheelchair (fold-up)

Motorized wheelchair Over-sized motorized wheelchair

Scooter (specify type)

Can you transfer in and out of your wheelchair or scooter independently?

Yes No Not Applicable

Is your wheelchair or scooter equipped with a lap belt? Yes No Not Applicable

Does the weight of you and your wheelchair or scooter exceed 700 pounds?

Yes No Don't Know Not Applicable

Do you have a wheelchair ramp? Yes No Not Applicable

\*\*\*NO EMERGENCY, GERI-CHAIR, STRETCHER, OR NURSING FACILITY TRANSPORTATION PROVIDED\*\*\*

All information provided in this application determines eligibility. Please complete as much as possible.

**SEDGWICK COUNTY TRANSPORTATION  
PHYSICAL DISABILITY STATEMENT—TO BE COMPLETED BY A PHYSICIAN ONLY**

If you are physically disabled, this page is to be completed by your physician. This information is needed in order to better serve you, to confirm your disability, and to qualify you for rides subsidized by Sedgwick County. All information provided will be strictly confidential. **If you do not have a physical disability, or if you reside outside the city of Wichita, this statement does not need to be completed and you may qualify for other subsidized rides.**

***The following disabilities do not automatically qualify you for the program. If your disability is not listed below your rides do not qualify to be partially subsidized by Physical Disability Mill Levy funds:***

**WRITE IN'S WILL NOT QUALIFY AS A COVERED DISABILITY.**

\_\_\_\_\_ **Restricted mobility:** Disabilities requiring the use of a wheelchair, cane, crutches, leg braces, walker or other orthopedic devices used to assist an individual.

\_\_\_\_\_ **Loss of extremities:** Anatomical deformity or amputation of hands, one hand and one foot, or loss of major function.

\_\_\_\_\_ **Stroke:** Ongoing debilitation effects following occurrence of a stroke.

\_\_\_\_\_ **Cardio-pulmonary disease:** Serious loss of heart or lung reserves; in spite of medical treatment, there is breathlessness, pain or fatigue.

\_\_\_\_\_ **Legally blind:** Severe visual impairment that is bilateral and not correctable with lenses.

\_\_\_\_\_ **Legally deaf:** Hearing impairment that is bilateral and not correctable with a hearing aid.

\_\_\_\_\_ **Epilepsy:** Convulsive or non-convulsive. (Service may be limited to six months.)

\_\_\_\_\_ **Neurological disabilities:** Neurological and physical impairments not controlled by medication (i.e., cerebral palsy or multiple sclerosis). *\*This category does not include diagnosed mental illnesses.*

\_\_\_\_\_ **Dementia:** Memory impairment so severe it affects daily living (including Alzheimer's).

Is the disability permanent? \_\_\_\_\_ Yes \_\_\_\_\_ No

If temporary, estimated duration is \_\_\_\_\_ months (this does not include pregnancy).

I hereby certify that the applicant \_\_\_\_\_ is a person with disability as defined by the preceding criteria and that the information contained in this form is true.

\_\_\_\_\_  
**Physician Name (please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Address**