METRO PLUS PARATRANSIT ELIGIBILITY APPLICATION

*Please complete entire application, including page 6 (Medical Release Form) before submitting. Incomplete applications will be mailed back to applicant. See instructions for ways to submit applications on page 5.

Personal Information

Name _____ Birth Date_____

Email Address_____

Home Address_____

City _____ State _____ Zip_____

Mailing Address_____

City _____ State _____ Zip_____

Email Address _____

Cell Phone _____ Home Phone_____

Emergency Contact:_____

Emergency Contact Phone_____ Relationship_____

Disability and Functional Limitation Information

1. Please describe your current health condition or disability in detail:

_____

_____

_____

_____

2. Is your health condition or disability temporary?

☐ No ☐ Yes, expected end date ____/____/____ or (___ months)

3. Does your health condition or disability change from day-to-day in ways that affect your ability to use the fixed route bus service?

☐ No ☐ Yes, please explain _____

_____

4. Explain any other aspect of your health/disability not covered above.

_____

_____

_____

Communication

1. Can you use a telephone or TTY to call?

☐ Yes ☐ Sometimes ☐ No ☐ Needs Assistance

If Sometimes, No or Needs Assistance, please explain _____

_____

2. Can you follow written and verbal instructions?

WRITTEN INSTRUCTIONS: ☐ Yes ☐ Sometimes ☐ No

VERBAL INSTRUCTIONS: ☐ Yes ☐ Sometimes ☐ No

If Sometimes or No, please explain _____

_____

_____

Present Means of Travel

1. How do you currently meet your transportation needs? _____

_____

2. What assistance do you require when traveling? (Check all that apply.)

_____ Support Cane
_____ Long Cane/White Cane
_____ Service Animal
_____ Crutches
_____ Wheelchair (Power)
_____ Walker
_____ I need help transferring to a seat
_____ Electronic Travel Aid
_____ Personal Care Attendant
_____ Powered Scooter
_____ Prosthesis
_____ Wheelchair (Manual)
_____ Portable Oxygen
_____ Other _____

A. If you use a wheelchair or scooter/cart, is it:

☐ More than 30 inches wide ☐ More than 48 inches long

B. Will it weigh more than 600 pounds when occupied?

☐ Yes ☐ No

3. Do you require a Personal Care Attendant (PCA)* when you travel?

☐ Always ☐ Sometimes ☐ Never

Name of PCA: _____

** A PCA is someone designated or employed by a person with a disability to assist that person in meeting his or her personal needs and/or to facilitate travel for a specific trip. A companion is **not** considered a PCA.*

4. Are there any conditions (such as extreme heat or cold weather) that limit the amount of time you can be outside?

☐ Yes ☐ Sometimes ☐ No

If Sometimes or No, please explain _____

_____

Transit Travel Information

1. Have you attempted to use a Metro fixed route bus in the last 3 months?

☐ Yes ☐ No If Yes, please explain your experience _____

_____

2. Check all that apply <u>if you are **NOT** currently riding fixed route buses</u>:

_____ I don't know how to ride the regular fixed route bus.
_____ I'm afraid to ride the regular fixed route bus.
_____ I don't want to ride the regular fixed route bus.
_____ It is too far to get to the regular fixed route bus.
_____ The ground is too uneven or steep for me to get to the bus stop.
_____ There are not sidewalks where I live.
_____ I need a wheelchair lift or ramp to board the bus.
_____ I can use the regular fixed route bus under certain circumstances.
_____ I cannot recognize a destination or landmark.
_____ Other (Please explain) _____

3. Can you transfer from one fixed route bus to another?

☐ Yes ☐ Sometimes ☐ No

If Sometimes or No, please explain _____

_____

4. Are you able to make your way to and from the nearest bus stop to your home, either with or without mobility aids?

☐ Yes ☐ Sometimes ☐ No

If Sometimes or No, please explain _____

_____

5. Can you walk/travel 4 blocks or less?

☐ Yes ☐ No

6. Can you wait outside for 15 minutes

☐ Yes ☐ No

7. Would you like training on how to use the fixed route bus service?

☐ Yes ☐ No

Certification

A. I certify that the information I give in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform those services.

_____

Applicant Signature *Date*

B. Person completing form other than applicant (please check one):

☐ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

☐ I certify that the information provided in this application is true and correct, based upon my knowledge of the applicant's health condition or disability.

Exceptions or Additions: _____

_____

Print Name _____ Date _____

Signature _____ Daytime Phone #_____

Relationship to Applicant _____

Agency _____

Address _____

City _____ State _____ Zip _____

Authorization for Release of Medical/Psychological Records

(Must be completed by applicant, Not Physician)

THE FORM ON THE NEXT PAGE IS TO BE COMPLETED BY YOU, THE APPLICANT, AND NOT BY YOUR PHYSICIAN, PSYCHIATRIST OR HEALTH CARE PROFESSIONAL. A SEPARATE FORM MAY BE SENT TO HIM/HER TO CONFIRM THE INFORMATION YOU HAVE PROVIDED.

NOTE: Disability verification by a qualified professional **does NOT guarantee eligibility, but it can play a major role in the eligibility determination process**. While verification by a physician is NOT required, it is important that any professional that verifies another individual's disability be familiar not only with that person's particular disability, but with an individual's ability or inability to travel on Metro's regular bus system. This information is confidential and will NOT be shared with any other person or agency, with the possible exception of another transit provider or transportation program to facilitate travel in those areas.

Application Submission

Please return application by mail to:
Attn: ADA Representative
1137 E 5000N Rd
Bourbonnais, IL 60914

Fax:
Attn: ADA Representative
(815) 929-3215

E-mail:
MetroPlus@RiverValleyMetro.com

Questions? Please call:
Phone (815) 935-1403 extension 244

NOTE: Only the following professionals are authorized to verify your disability:

Licensed Physician, Psychiatrist, Physical Therapist (PT), Occupational Therapist (OTR), Certified Rehabilitation Counselor (CRC), and Orientation and Mobility Specialist (O&M).

Release of Medical/Psychological Records

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to River Valley Metro Mass Transit District and its representatives all of my medical records for the determination of my eligibility for Metro Plus paratransit services.

Name of Professional: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #:_____

Name of Professional: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____Fax #:_____

APPLICANT INFORMATION

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

PARENT OR LEGAL GUARDIAN INFORMATION *

NAME (PRINT): _____

SIGNATURE: _____ DATE: _____

***Applicant signature or Parent/Legal Guardian signature is required.**