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. 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 if you are **NOT** currently riding fixed route buses:

_____ 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:
River Valley Metro Mass Transit
Attn: ADA Representative
1137 E 5000N Rd
Bourbonnais, IL 60914

Fax:
Attn: ADA Representative
(815) 929-3258

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.**