



METRO PLUS PARATRANSIT ELIGIBILITY APPLICATION

This service is an appointment-based transportation service. This service does not qualify for the free rides Benefit Access program. A fare is required for this service.

All 6 pages must be filled out completely, or the application will be returned.

See Page 5 for instructions on submitting the application.

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.)

- | | |
|---|--|
| <input type="checkbox"/> Support Cane | <input type="checkbox"/> Electronic Travel Aid |
| <input type="checkbox"/> Long Cane/White Cane | <input type="checkbox"/> Personal Care Attendant |
| <input type="checkbox"/> Service Animal | <input type="checkbox"/> Powered Scooter |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Wheelchair (Power) | <input type="checkbox"/> Wheelchair (Manual) |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Portable Oxygen |
| <input type="checkbox"/> I need help transferring to a seat | <input type="checkbox"/> 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 no 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 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.**