"OPERATION UPLIFT"

ADA PARATRANSIT ELIGIBILITY APPLICATION FORM
- 2018 -

In compliance with the Americans with Disabilities Act of 1990 (ADA), the Decatur Public Transit System (DPTS) provides "paratransit" (i.e. van or taxi shared ride) service to anyone with a disability who cannot use DPTS buses and who is traveling in an area served by DPTS fixed route buses. This paratransit van or taxi shared ride service is intended only for those trips that the person cannot make on DPTS buses. This application form is intended to determine when and under what circumstances the applicant can use DPTS buses and when paratransit van or taxi shared ride service is required. Before completing this application form, please read the enclosed Operation Uplift brochure for more details.

INSTRUCTIONS FOR COMPLETING THIS FORM:

The applicant (or someone assisting the applicant) must complete PARTS 1 through 3. A ***licensed physician*** must complete and sign the MEDICAL VERIFICATION section.

All applicants, whether new applicants or persons applying for recertification, must complete an application. All questions must be answered. Incomplete forms will be returned. Transit System staff members may contact you for clarification. If you have any questions or need assistance completing this form, please call: (217) 424-2821.

Please note that the applicant's home address is required, not the address of a nursing home or any other temporary residence.

WHEN COMPLETED, PLEASE RETURN THIS FORM TO:

Decatur Public Transit System
353 East William Street
Decatur, IL 62523
Fax: (217) 424-2870

Your application will be reviewed by a committee of Transit System staff members, and you may be asked to come in for a personal evaluation, to better assess your ability to use DPTS's bus system. You will be notified in writing of the review committee's decision within 21 days of receipt of the fully completed application.

- If you have been approved for Operation Uplift, you will be asked to go to the Transit Center to have your photo taken and to pick up your ID card.
- If you have been denied or approved for only conditional or temporary eligibility, you will be informed of your right to appeal the decision.

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----- Van and Taxi Program -----

New Application? ☐
Recertification? ☐

PART 1. GENERAL INFORMATION

PLEASE PRINT CLEARLY

Last Name:_____ First Name:_____ MI:____ Male ☐ Female ☐

Home Address:_____Apt:_____

Are you located in a Nursing Home? Yes_____ No_____

If Yes Is it? Permanent_____ Or Temporary_____

Are you a Medicaid recipient? Yes_____ No_____

City:_____State:_____Zip Code:_____

Telephone (___)_____Date of Birth:_____Age:_____

If someone assisted you in completing this form, please identify him/her below:

Name:_____ Telephone: (___)_____

Relationship:_____ FAX: (____)_____

PART 2. APPLICANT'S CERTIFICATION

I understand that the purpose of this application is to determine if there are times when, as a result of a disability, I cannot use the bus service provided by DPTS and must therefore use the paratransit van or taxi shared ride service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this application is true and correct. I authorize the medical doctor who provided medical verification to release information relating to the disability to DPTS or to any health professional contracted by DPTS to perform eligibility determinations.

Applicant's Signature:_____Date:_____
(MUST be signed by the applicant or someone with Power of Attorney.)

For DPTS staff: Rev. 06/2018

Date Application Received for Review: _____

PART 3. INFORMATION ABOUT THE APPLICANT'S DISABILITY

1. What type or types of disabilities prevent you from using DPTS buses? (Check all that apply)

   ☐ Physical disability
   ☐ Visual impairment/blindness
   ☐ Developmental or cognitive disability
   ☐ Mental illness
   ☐ Other _____

   Please describe your disability in more detail:_____

2. Is the disability described above temporary or permanent?
   ☐ Temporary, I expect it to last for another_____months
   ☐ Permanent
   ☐ I do not know

3. Does the severity of your disability change from day to day, perhaps because of the weather or medical treatments you receive (i.e. dialysis or chemotherapy)?
   ☐ NO
   ☐ Yes (Please explain):_____

4. Please indicate below if you use any of the following mobility aids or equipment:

   ☐ Crutches
   ☐ Cane
   ☐ Walker
   ☐ Manual wheelchair
   ☐ Electric scooter
   ☐ Alphabet or picture board
   ☐ Long White Cane
   ☐ Leg Braces
   ☐ Electric wheelchair
   ☐ Other (describe): _____
   ☐ I do not use any mobility aids or equipment.

   NOTE: We may not be able to accommodate you if your wheelchair/scooter is longer than 48 inches or wider than 30 inches, or if your total weight with your wheelchair is more than 600 pounds

5. If you require a service animal when you travel, please indicate the type of animal:

6. If you require the assistance of a Personal Care Attendant (PCA) when you travel, please indicate the type of service(s) the PCA is intended to provide:

7. Using a mobility aid or on your own, how far can you travel?

- ☐ I cannot go outside my house/apartment
- ☐ I can only get to the curb in front of my house/apartment
- ☐ I can walk (use wheelchair) up to 1 block
- ☐ I can walk (use wheelchair) up to 3 blocks
- ☐ I can walk (use wheelchair) up to 6 blocks
- ☐ I can walk (use wheelchair) more than 6 blocks

8. What keeps you from traveling further? (Please check all that apply):

- ☐ I cannot cross the street if there are no curb-cuts
- ☐ I cannot walk (use wheelchair) if the street or sidewalk is too steep
- ☐ I cannot cross busy streets and intersections
- ☐ I cannot travel outside when it is too hot or too cold
- ☐ I Cannot find my way at night because of a _____ vision problem
- ☐ I get confused and cannot find my way
- ☐ Other, please explain: _____

_____

9. Can you ask for and follow written or oral instructions?

- ☐ YES
- ☐ NO
- ☐ Sometimes

If you choose No or Sometimes, please explain: _____

_____

10. Can you wait outdoors for up to 30 minutes

- ☐ Yes
- ☐ Yes, but only if there is a place to sit
- ☐ Yes, but only if it's not too hot or to cold
- ☐ No, please explain: _____

_____

11. Can you climb three steps with a handrail without assistance?

☐ Yes
☐ NO

PART 4: QUESTIONS ABOUT USING DPTS BUSSES

12. Have you ever used DPTS buses?

☐ Yes, I typically use DPTS buses_____times a week
☐ Yes, I used to but stopped because_____

_____

☐ No

13. Did you know that all DPTS buses and trolleys are wheelchair accessible, and that most of the buses in DPTS active fleet have ramps instead of steps?

☐ Yes
☐ No

14. Please explain how your disability prevents you from using DPTS buses:

_____

_____

_____

_____

_____

15 If someone helped you get on a DPTS bus, would you know where to get off the bus or could you find out by yourself?

☐ Yes

☐ No

☐ Sometimes

16. If you choose either No or Sometimes In #15 above, check all that apply:

- ☐ I get confused and cannot remember where I am going
- ☐ I could if the driver called out the streets
- ☐ I probably could with travel signs
- ☐ Other: (Please explain):_____

_____

17. Please describe any other conditions which limit your ability to use DPTS buses, and which you believe make you eligible for "Operation Uplift" paratransit van or taxi shared ride service:_____

_____

_____

_____

_____

_____

_____

_____

If you have any questions or concerns feel free to contact:
Paratransit Coordinator
Angela Horges
hHorges@decaturil.gov
217/542-3562

MEDICAL VERIFICATION

(***MUST*** be completed by a **Licensed Physician**)

PATIENT INFORMATION	NAME: _____ ADDRESS: _____ _____ TELEPHONE: _____

The Americans with Disabilities Act of 1990 (ADA) requires that the Decatur Public Transit System (DPTS) provide "paratransit" service to anyone who cannot use DPTS fixed route buses because of a disability. DPTS provides door-to-door paratransit services in the Decatur area using private taxicabs and wheelchair accessible vans. The person who has asked you to review and sign this application is applying to DPTS to be considered eligible for this paratransit service because of a claimed disability.

ADA paratransit van or taxi service is intended only for those trips the person cannot make using DPTS buses. This application is intended to help to determine when and under what circumstances the applicant can use DPTS buses and when he/she requires door-to-door paratransit van or taxi service.

Please carefully review the information provided by the applicant in this application and then answer the following questions:

1. Please describe all conditions (physical, visual, cognitive, or other) which functionally prevent the applicant from using DPTS fixed route buses.

   _____

   _____

2. How does this condition(s) PREVENT the applicant from using the DPTS fixed route bus service?

   _____

   _____

3. Are there any circumstances under which the applicant could use DPTS buses? YES____ NO____

   Please explain: _____

   _____

4. To the best of your knowledge, is the information provided by the applicant in Parts 2, 3, and 4 of this application true and correct? YES ____ NO ____

5. Based on your professional opinion, do you feel that the applicant qualifies for ADA van and taxi ride share service (paratransit)? YES ____ NO ____

6. Will a personal care attendant (PCA) be needed when transporting the client to and from their destination? YES ____ NO ____ (lack of ability to determine sense of direction should answer YES).

7. List of medication:

   _____

   _____

   _____

Signature: _____

Print name and title: _____

State of Illinois license # _____

Business address: _____

Telephone number: (_____) _____

MEDICAL RELEASE AUTHORIZATION

In order to allow the Decatur Public Transit System to evaluate your request, it may be necessary to contact a physician or other professionals to confirm the information you have provided. Please complete the following information and authorization form.

* * * * * * *

The following Health Care Professional is familiar with my disability and is authorized to provide information to the Decatur Public Transit System (DPTS) or to any health professional contracted by DPTS to perform eligibility determinations.

Physician's Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____

Applicant's Signature: _____
(<u>MUST</u> be signed by the applicant or someone with Power of Attorney.)

Date: _____