

## Application for Determination of Paratransit Services

This form is to apply for CityLift paratransit services. CityLift paratransit service provides door to door services in specially equipped vans. The service is design for people who cannot use the CityLink fixed-route bus service due to a disability that prevents getting to or riding on a fixed route bus.

The information in this application will be used by CityLink Compliance Coordinator to aid in the determination of your eligibility to use paratransit service.

### **All information remains confidential.**

If your disability prevents you from completing this application in this format, please call CityLink Compliance Coordinator at (309) 679-8139 and ask for assistance.

The CityLink Compliance Coordinator must receive a diagnosis of your disability from your physician on ~~your physician's prescription pad paper~~. CityLift cannot and will not accept a diagnosis that is written on any other paper.

When this form is completed and returned to CityLink Compliance Coordinator along with a diagnosis from your physician's office, we will then make a determination and arrangements if required for you to visit our Assessment Center to complete the process.

If you are required to visit the assessment center, we will make all the arrangements by scheduling with you the report date and time. There will be no cost to you for the assessment or the transportation.

You will be notified of eligibility within 21 days from the time CityLink Compliance Coordinator receives your completed application, your physician's diagnosis of your condition, and a report from the Assessment Center.

If you are denied and wish to reapply, you physician's diagnosis will need to identify a significant change in the original diagnosis. You of course have the option to appeal our final decision regarding your eligibility.

This application is consistent with the requirements of the American with Disability Act, (ADA).

### Before you can ride CITYLINK Paratransit Service

1. Answer all the questions in this application completely and sign it.
2. Submit your completed application to:

**CITYLINK**  
**Attn: John Williams**  
**2105 NE Jefferson Ave**  
**Peoria, IL 61603**

PART A

**PLEASE PRINT**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Mr.            Mrs.            Ms.            (circle one)

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (daytime) \_\_\_\_\_ (evening) \_\_\_\_\_

Date of Birth (M D Y) \_\_\_\_\_ Social Security #: \_\_\_\_\_

**In Case Of Emergency, (notify):**

Name \_\_\_\_\_

Phone \_\_\_\_\_

Relation to self \_\_\_\_\_

Do you reside with: Family            By Yourself            Group Home

(circle one)                                  Supported Living            Nursing Center

Have you ever applied for a GP Transit, CITY LINK, ADA Certification Card for paratransit services before? YES \_\_\_\_\_ No \_\_\_\_\_ (check one)

If yes, tell us when you applied \_\_\_\_\_ (date)

**PART A**

**Please answer the following questions. If you have any questions about the application, please contact Citylink.**

1. What disability prevents you from using the Citylink fixed route buses?

2. Is your medical condition and/or disability temporary?

\_\_\_\_\_ Yes or No \_\_\_\_\_

3. Does your disability prevent you from getting to and from a bus stop?

\_\_\_\_\_ Yes or No \_\_\_\_\_  
If yes please explain...

a. Using a mobility aid or on your own, how far are you able to travel without the assistance of another person?

3 blocks    6 blocks    9 blocks    < less than 3 blocks

b. Can you recognize your destination?

\_\_\_\_\_ Yes or No \_\_\_\_\_  
If no, please explain.....

c. Do you have difficulty receiving verbal or written directions?

Is there a physical barrier combined with your disability that prevents travel to or from a bus stop? (Example: stairs, no side walks, no curb cuts, heat, cold, ice, snow etc....)

\_\_\_\_\_ Yes or No \_\_\_\_\_ Sometimes \_\_\_\_\_

If yes or sometimes please explain.....

PART A

Due to the limitations of my disability, I can wait outside at a fixed route bus stop only if: (circle all that apply)

- a.) I can always wait outside at a bus stop.
- b.) There is a bench to rest on.
- c.) There is some sort of shelter from the weather.
- d.) The wait is no longer than \_\_\_\_\_ minutes.
- e.) The temperature is above \_\_\_\_\_ degrees.
- f.) The temperature is below \_\_\_\_\_ degrees.
- g.) I can never wait outside at a bus stop because:

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Due to the limitations of my disability, I can ride an accessible bus, (wheelchair lift equipped) operating on the fixed-route only if: (circle all that apply)

- a.) I can always ride on an accessible fixed-route bus.
- b.) I have an attendant with me. Personal Assistant
- c.) I am familiar with the route.
- d.) I have received travel training.
- e.) A seat is available for me on the bus.
- f.) I can never ride on an accessible fixed-route bus because:

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PART A
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Due to the limitations of my disability I can recognize my destination and leave the bus only if: (circle any that apply)

- a.) I can always recognize my destination and leave the bus.
  - b.) I receive travel training as to where my bus stop is.
  - c.) The driver announces my stop for me.
  - d.) I can never recognize my destination and leave the bus because:
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1. Which of the following mobility/ communication aids do you use? ( Please check all that apply.)

- Cane  White Cane  Walker  Crutches
- Manual Wheel Chair  Powered Wheel Chair  Powered Scooter / Cart
- Boarding Chair  Service Animal  Communication Aid  Portable Oxygen
- Transfer Board  Prosthesis  None of These

2. If you use a wheel chair or scooter:

Is it more than 30 inches wide?  Yes  No

Is it more than 48 inches long?  Yes  No

Is the combine weight of device and occupant more than 600 pounds?

Yes  No

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# Institute of Physical Medicine & Rehabilitation

Please fill out the following questionnaire for the IPMR testing and return it to CityLink with your completed application.

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

In case of emergency, notify \_\_\_\_\_

Phone # \_\_\_\_\_

List all medications you are currently taking:

<u>Medication</u>	<u>Dosage</u>	<u>Times/Day</u>	<u>Prescribing Physician</u>	<u>Telephone #</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all allergies: \_\_\_\_\_

Do you currently have, or have you had in the past, any of the following? Please circle if yes.

<u>Explain</u>	<u>Explain</u>
1. Heart Attack _____	12. Emphysema _____
2. Chest Pain _____	13. Epilepsy or Seizures _____
3. Heart Pacemaker _____	14. Artificial Joints _____
4. Heart Surgery _____	15. Rheumatoid Arthritis _____
5. High Blood Pressure _____	16. Osteoarthritis _____
6. Stroke _____	17. Irritable Bowel Syndrome _____
7. Cancer _____	18. Gastric Ulcer _____
8. Diabetes _____	19. Kidney Disorder _____
9. Visual Problems _____	20. Blood Transfusion _____
10. Hearing Deficits _____	21. Hepatitis A, B, C _____
11. Asthma _____	22. Infectious Diseases _____

Other Problems (Please List) \_\_\_\_\_

Surgeries: \_\_\_\_\_

	NO	YES	If Yes, YEAR
Have you ever skin tested <b>positive</b> for Tuberculosis?	_____	_____	_____
Was treatment recommended?	_____	_____	_____
Did you receive treatment?	_____	_____	_____

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_



## PERSONAL ASSISTANT (PA) CERTIFICATION

Complete this form only if you require a Personal Assistant to provide aid to you while traveling.

Passenger Name: \_\_\_\_\_

Personal Assistant (PA) Name: \_\_\_\_\_

PA's Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip \_\_\_\_\_

PA's Home Phone Number: \_\_\_\_\_

PA's Work Phone Number: \_\_\_\_\_

Do you provide assistance on a Full time or Part-time basis?

Full Time

Part Time

I certify that I need the services of a personal assistant to make independent travel possible. A Personal Assistant is employed specifically by me or for me and assists me with the completion of at least one daily activity on a regular basis.

I will need a Personal Assistant to travel with me at all times.  YES  NO

If temporary, provide the expected duration of time: \_\_\_\_\_

**I certify the information above is TRUE and CORRECT.**

\_\_\_\_\_  
Signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_