

Application for Determination of CityLift 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 designed 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 the CityLink Mobility Management Department 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 Mobility and Special Services Department at (309) 679-8183 and ask for assistance.

The CityLink Mobility Management Department **must receive a statement from your physician on their prescription pad or official letterhead stating your disability or disabilities make you unable to use the fixed route and in their professional opinion believe you are eligible for CityLift services AND a completed medical professional section that is attached.** CityLift cannot and will not accept a statement that is written on any other paper.

When this form is completed and returned to the Mobility Management Department along with the Physician's statement and Medical professional section, 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 the appointment and transportation at no cost to you.

You will be notified of eligibility within 21 days from the time the CityLink Mobility and Special Services Department 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, your 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 Americans with Disabilities Act (ADA).

Please return completed applications to:

CityLink
Attention: Andrew Dwyer
2105 NE Jefferson Ave.
Peoria, IL 61603

OR FAX: (775) 416-9762

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CityLink ♦ 2105 NE Jefferson Street ♦ Peoria, IL 61603

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PLEASE PRINT

Last Name _____ First _____ Initial _____

Check One : Mr. Mrs. Ms.

Address _____ Apt. # _____

City _____ Zip Code _____

Phone (daytime) _____ (evening) _____

Date of Birth (M D Y) _____ Social Security # _____

Do you reside with: (circle one) Family By Yourself Supported Living (Nursing or group)

In Case of Emergency Notify (List supported Living Contact, if applicable):

Name _____ Phone _____

Relation to self _____

Have you ever applied for a GP Transit, CityLink ADA Certification Card for Paratransit services before?

YES No If yes, when? _____ (date)

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 NO

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

YES NO

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

<less than 3 blocks 3 blocks 6 blocks 9 blocks

b. Can you recognize your destination?

YES NO

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

YES NO

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

YES NO SOMETIMES

- If YES or SOMETIMES, please explain:

4. 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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5. 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 Care Attendant)
 - 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:
-

6. 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 received 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:
-

7. Which of the following mobility/communication aids do you use? (Please check all that apply).

- | | | |
|---|---|---|
| <input type="checkbox"/> Cane | <input type="checkbox"/> White Cane | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheel Chair | <input type="checkbox"/> Powered Wheelchair |
| <input type="checkbox"/> Powered Scooter/Cart | <input type="checkbox"/> Boarding Chair | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Communication Aide | <input type="checkbox"/> Portable Oxygen | <input type="checkbox"/> Transfer Board |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> None of These | |

- a. If you use a Wheelchair or Scooter:
- Is it more than 30 inches wide? Yes No
- Is it more than 48 inches long? Yes No
- Is the combined weight of the device and occupant more than 800 pounds?
- Yes No

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8. Is there anything else about your disability and how it affects your ability to use public transportation? Please provide any information you feel would help:

I hereby certify that to the best of my knowledge, the information given in this document is true and correct.

Signature of Applicant

Date

Signature of person other than applicant

Date

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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: _____ State: _____ 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: ____/____/____

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Medical Professional Section (Completed by your Primary Care Physician)

Please fill out the following questionnaire for the IPMR testing and return it to CityLink with your completed application. **In addition to this form, your physician will need to provide a diagnosis of your disability which states why you are unable to ride the fixed route on the physician's prescription pad paper.**

Name _____ Date of Birth _____

List all medications you are currently taking: (If not enough space, please use back page)

Medication	Dosage	Times/Day	Prescribing Physician	Telephone #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

- | Explain | Explain |
|------------------------------|------------------------------------|
| 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 tested positive for Tuberculosis?	_____	_____	_____
Did you receive treatment?	_____	_____	_____

_____ Physician Signature	_____ Printed Name	_____ Date
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Physician Portion – Additional Information