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 that 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 our Transportation Specialist, Carla Jackson for assistance at 309.679.8183.

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: Carla Jackson
407 SW Adams
Peoria, IL 61602

EMAIL: cjackson@ridecitylink.org OR FAX: 775.416.9762

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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) _____

Email Address_____

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 applicant _____

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.

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 can you 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:

      _____

3. 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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4. 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:

    _____

5. 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:

    _____

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

☐ Cane	☐ White Cane	☐ Walker
☐ Crutches	☐ Manual Wheelchair	☐ Powered Wheelchair
☐ Powered Scooter/Cart	☐ Boarding Chair	☐ Service Animal
☐ Communication Aide	☐ Portable Oxygen	☐ Transfer Board
☐ Prosthesis	☐ 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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7. Are you able to travel independently or do you require a Personal Care Attendant (PCA) to assist you?

   ☐ NO PCA ☐ Full time PCA ☐ Part-time PCA

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:

_____

If you have any questions about the application, please contact CityLink.

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

Medical Professional Section (Completed by your Primary Care Physician)

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Please fill out the following questionnaire for our independent assessor. In addition to this form, your physician will need to provide a statement about your disability and why that disability makes you unable to ride the fixed route. This must be on the physician's prescription pad paper or official letterhead.

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

CityLink ✦407 Adams ✦Peoria, IL 61602