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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Medical Professional Section (Completed by your Primary Care Physician)

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