AMERICANS WITH DISABILITIES ACT (ADA)
PARATRANSIT ELIGIBILITY APPLICATION
FOR SERVICE ON THE CITY OF GALESBURG
HANDIVAN PARATRANSIT SYSTEM

HANDIVAN TRANSPORTATION DIVISION
GALESBURG COMMUNITY CENTER
1025 Monmouth Blvd.
Office Hours: 7a-5p
Monday through Saturday
GALESBURG, IL 61401
345-3686 VOICE/TTY

2017

PART A

APPLICANT INFORMATION

The City of Galesburg's Handivan Transportation Service is provided for disabled persons unable to use fixed route services such as the City Bus because of a certifiable condition that meets specific criteria established under the Americans with Disabilities Act of 1990 Title II (b) for eligibility for paratransit transit service. **All information collected in this application is confidential and will not be shared with anyone, unless specified in writing by the applicant or the applicant's representative.**

How To Apply For Handivan Paratransit ADA Eligibility

Please read carefully:

1. Fill out **PART A** of this application. If you need help filling out this part or if you have questions please call the office at 345-3686, Monday through Friday 7 a.m. to 5 p.m.
2. Take, send, or fax the application to your health care professional to have **PART B** completed.
3. Mail the completed application to **HANDIVAN, 1025 Monmouth Blvd., GALESBURG IL 61401.**
4. The HANDIVAN office will notify you as to your eligibility status.
5. If you have not heard about your eligibility status within 21 days of submitting your application, please call **(309) 345-3686.** If a determination has not yet been made, you will be temporarily eligible to ride Handivan.

If you are denied eligibility, you will have a right to appeal the eligibility decision. Please contact the **HANDIVAN** office for details on the appeals process.

1. NAME OF APPLICANT_____

2. ADDRESS_____

3. CITY_____STATE_____ZIP_____

4. TELEPHONE (HOME)___(___)_____

Other Daytime Telephone Number __(___)_____

5. DATE OF BIRTH ___/___/____

6. MALE_____ FEMALE_____

7. In case of an emergency, is there someone in the local area who should be notified?

YES⇨ NO⇨

NAME_____ PHONE (___)_____

ADDRESS_____RELATIONSHIP_____

___

PART A - TO BE COMPLETED BY APPLICANT

Check the category and all criteria that apply:

_____I have a physical, mental, or visual, disability, or impairment, which PREVENTS me from utilizing, fixed route buses. NOTE: All fixed route buses operated by the City of Galesburg are accessible.

For:

(1) ____ Boarding

(2) _____Riding

(3) _____Disembarking

(4) _____Other (describe):_____

_____CATEGORY 2

I can use the bus, but have I have an impairment - related condition, which prevents me from traveling to/from a bus boarding location.

Describe the impairment or condition:_____

_____

_____

PART A DISABILITY OR HEALTH INFORMATION

Indicate all conditions which affect your ability to use the bus and require that you use the HANDIVAN.

Check all that apply:

1. General Medical Conditions:

_____None _____ Kidney Failure _____Pneumonia _____Cancer _____Diabetes

Other _____

2. Bone and Joint Conditions:

_____None _____Broken Bone _____Amputation of: _____ _____Fusion

_____Osteo-arthritis _____Rheumatoid Arthritis _____Scleroderma

Other _____

3. Brain/Nerves/Muscle Conditions

_____ None _____Alzheimer's Disease _____Hemiplegia _____Post-polio

_____Brain Injury _____Huntington's chorea _____Quadriplegia

_____Cerebral Palsy _____Multiple Sclerosis _____Spina Bifida

_____Dementia _____Muscular Dystrophy _____Stroke

_____Epilepsy _____Paraplegic _____Guillian-Barre _____Parkinson's Disease

Other _____

4. Heart and Circulatory Conditions

_____None _____Cardio Vascular Disease _____Congestive Heart Failure

Other_____

5. Lung and Breathing Conditions

_____None _____Emphysema _____Pulmonary disease (COPD)

Other_____

6. Vision/Hearing/Speech Conditions

_____None _____Glaucoma _____Hard of Hearing

_____Autism _____Blind _____Partially Sighted

_____Deaf _____Macular Degeneration

_____Deaf-Blind _____Night Blindness _____Diabetic Retinopathy

Other_____

PART A

7. Developmental/Mental Conditions

_____None _____Mood Disorder ____Autism _____Psychosis

_____Thought Disorder

Other_____

8. Is your health condition or disability temporary?

_____**Yes** How long do you expect it to last? _____

_____**No** How long have you had this condition or disability?_____

9. Does your disability or health condition change from time to time in ways, which affect your mobility?

Yes, Please explain: _____

MOBILITY AIDS

Do you use any of the following aides? (Circle all that apply)

Manual Wheelchair Electric Wheelchair Power Scooter Cane

Crutches White Cane Guide Dog Walker Hearing Aid

Boarding Chair Communications Board Brace Prosthesis Oxygen

Other_____

*** Please note that your trip origin and destination must be accessible by ramp or lift. IF NOT ACCESSIBLE, please have someone available to assist you up and down steps. Drivers are not permitted to assist wheelchair customers up and down any steps.**

Are there any other effects of your disability that we need to be aware of?

Obesity/Weight Seizures Paralysis Shortness of Breath Dizziness

Other, please explain_____

10. Do you require a Personal Care Attendant when you use HANDIVAN ?

YES NO OCCASIONALLY

** The customer must provide his or her Personal Care Attendant. The Personal Care Attendant cannot be a registered Handivan Client and must be physically able to assist the rider.

If you have completed this application for another person you must provide the following information:

Your Name_____

Address_____

City_____ State_____

Daytime Phone Number (___)_____

Relationship to Applicant_____

Consent Form

WHO CAN CERTIFY: If your disability prevents you from using fixed route service and private transportation such as a taxi, one of the following health care professionals, as appropriate to your case, may be able to provide information that will aide in your certification as ADA paratransit eligible**. However,** the Health **Care professional does not determine final eligibility for Paratransit**.

The following health care professional is authorized to provide information to the City of Galesburg Handivan Division that is required to complete this certification, including PART B, and any clarifications required by the Handivan Division.

Clearly print the names of the health care professional who will be certifying your application and check the type of health care professional he or she is.

Name of Physican_____

I hereby certify that to the best of my knowledge the information given above is correct and I authorize the herein health professional named above to provide information to the City of Galesburg Handivan Division.

Signature of Applicant _____

REQUEST FOR PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked by the Handivan applicant to provide information regarding his/her ability to use our transit services. **Federal law requires that the City of Galesburg provide paratransit services to persons who cannot use fixed-route transit services.** The information you provide will allow us to evaluate this request and the applicant's eligibility to use Handivan Origin to Destination Transportation Service.

If you have any questions about completing this form or about the transportation provided by Handivan, please feel free to contact the Handivan office at 345-3686, Monday - Friday between the hours of 8 a.m. and 5 p.m.

Thank you for your cooperation.

To qualify for Handivan Service, a person **must be unable** to use regular public transit or a private unadapted vehicle such as a taxi, due to a physical or mental disability. **Individuals qualify if:**

1. As the result of their disability, they cannot board, ride or disembark from a City of Galesburg Transit Bus; or

2. They have a specific impairment-related condition which prevents them from getting to or from a bus stop.

PLEASE NOTE: This does not include persons who find it uncomfortable or difficult to get to and from a bus stop. Nor does it mean that persons who find it economically advantageous to use Handivan instead of the bus or a taxi, qualify for Handivan Service under the eligibility guidelines

Resources for this program are limited and your evaluation of each person must be based solely upon the individual's ability to use regular transit. Your verification should consider only the presence of a disabling condition, not the applicant's age or economic status. Please exercise care in evaluating applicants for this program. False verification could result in travel limitation for persons legitimately qualified to use the program.

A DETERMINATION OF THE APPLICANT'S ELIGIBILITY WILL BE MADE WITHIN 21 DAYS FOLLOWING THE RECEIPT OF THE APPLICATION.

IF YOU HAVE ANY QUESTIONS , YOU MAY CALL THE HANDIVAN OFFICE 309-345-3686

PART B - PROFESSIONAL VERIFICATION

ALL INFORMATION PROVIDED BY THE CLIENT OR THE HEALTH CARE PROFESSIONAL IS CONFIDENTIAL. Thank you for taking the time to complete this paperwork.

Handivan is a special transportation service for disabled persons who, because of a mental or physical disability, find it **impossible** to use regular public transportation. All parts must be completely filled out by the authorized person who signs below. Incomplete registration forms will be returned to the applicant.

A. Indicate (X) nature of applicant's disability (check as many items as may apply.)

1. ___ Non-Ambulatory (uses wheelchair for mobility)
2. ___ Impaired or Assisted Ambulation requiring:
3. ___ Arthritis
4. ___ Amputation
5. ___ Cerebrovascular Accident
6. ___ Pulmonary Ills

   Does applicant use a Potable Oxygen Tank? YES NO
7. ___ Neurological Handicap
8. ___ Cardiac Ills
9. ___ Kidney Disease Dialysis ____
10. ___ Sight Disabilities: Service Animal: YES NO
11. ___ Un coordination
12. ___ Mental retardation (circle level) Moderate Severe Profound
13. ___ Cerebral Palsy
14. ___ Autism
15. ___ Severe Muscle Spasms

PART B - PROFESSIONAL VERIFICATION

Disabilities continued. Please continue to check all that apply

16. ___ Seizures

17. ___ Loss of Consciousness

18. ___ Mental Illness - Please specify what it is about this cognitive disability that makes this individual unable to use regular public transit buses:

_____

_____

_____

___

If the applicant is ambulatory, please check the following:

Is the person:

__Able to walk **200 feet** without the assistance of another person?

__yes __no __sometimes

__Able to walk **1/4 mile** with the assistance of another person?

__yes __no __sometimes

__Able to walk **15 feet** without the assistance of another person?

__yes __no __sometimes?

__Able to climb 12-inch steps without assistance?

__yes __no __sometimes?

__Able to wait outside without support for ten minutes?

__yes __no __sometimes?

PART B - PROFESSIONAL VERIFICATION

19. ___Other (describe)

_____

_

B. The disability is _____ Permanent or _____Temporary if temporary, expected duration is_____months.

C. In your opinion, must this individual bring a competent attendant on each trip?____YES ____ NO

check only one please:

___ **Can** use regular public transit buses on a fixed route schedule.

___ **Can not** use regular public transit at all (includes taxis)

PART - PROFESSIONAL VERIFICATION

When did you last examine the patient? _____

If there is any other effect of the disability of which the Handivan office should be aware. Please provide explanation:_____

D. Your professional area of specialization:

___ Audiologist___ Psychologist___ Physical therapist___ Physician

___ Registered Nurse

Name:_____

Title:_____AGENCY/COMPANY NAME:_____

PROFESSIONAL LICENSE# (if applicable). _____ Phone: _____

Address: _____

I hereby certify that the above information is true. The City of Galesburg Handivan will (1) verify the validity of the license of the health professional providing the certification, (2) make the final determination on an applicant's eligibility for Handivan Paratransit Service.

_____ _____

SIGNATURE DATE

THANK YOU FOR YOUR ASSISTANCE