

**AMERICANS WITH DISABILITIES ACT (ADA)
CITY OF GALESBURG PARATRANSIT
ELIGIBILITY APPLICATION**



1025 Monmouth Blvd.

Monday through Saturday

GALESBURG, IL 61401

345-3686 VOICE/TTY

343-0576 FAX

The City of Galesburg does not discriminate in the provision of programs, services or activities on the basis of race, color, creed, religion, national origin, sex, age, or disability. Nor does the City employ standards that would tend to screen or limit the participation of individuals in any of the programs, activities, or services sponsored by the City of Galesburg on the basis of race, color, creed, national origin, sex, age or disability.

APPLICANT INFORMATION

The City of Galesburg's Paratransit 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 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 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 7:00 a.m. to 5 p.m. and Saturday 8:00 a.m. to 5:00 p.m.
2. Take or send the application to your health care professional to have **PART B** Completed.
3. Mail the completed application to **PARATRANSIT, 1025 Monmouth Blvd, GALESBURG IL 61401.**
4. The City of Galesburg Transit Office will **notify** you as to your eligibility status.

NAME OF APPLICANT_____

ADDRESS_____

CITY_____STATE_____ZIP_____

TELEPHONE (HOME)(____)_____

Other Daytime Telephone Number (____)_____

DATE OF BIRTH ____/____/____

MALE_____ FEMALE_____

Are you a Veteran? Yes_____ NO_____

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

YES ☐ NO ☐

NAME_____ PHONE (____)_____

ADDRESS_____

RELATIONSHIP_____

If you have not heard about your eligibility status within 21 days of submitting your application, please call **(309) 345-3686 voice/TDD**. If a determination has not yet been made, you will be temporarily eligible to ride Paratransit.. If you are denied eligibility, you will have a right to appeal the eligibility decision. Please contact the City of Galesburg Transit office for details on the appeals process and ask for Dedra Mannon.

PART A - TO BE COMPLETED BY APPLICANT

Check only one category that applies:

____ CATEGORY 1

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

Describe the impairment or condition: _____

DISABILITY OR HEALTH INFORMATION

Indicate all conditions which affect your ability to use the city bus and **requires that you use the PARATRANSIT services. Check all that apply:**

1. General Medical Conditions:

☐ None ☐ Kidney Failure ☐ Pneumonia ☐ Cancer ☐ Diabetes

Special Notes _____

2. Bone and Joint Conditions:

☐ None ☐ Broken Bone ☐ Amputation of: Arm/ Leg ☐ Fusion

☐ Osteo-arthritis ☐ Rheumatoid Arthritis ☐ Scleroderma

Special Notes _____

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 ☐ Paraplegia ☐ Vertigo/Dizziness

☐ Guillian-Barre ☐ Parkinson's Disease

Special Notes _____

4. Heart and Circulatory Conditions

_____None _____ Cardio Vascular Disease _____ Congestive Heart Failure

Special Notes _____

5. Lung and Breathing Conditions

_____None _____ Emphysema _____ Pulmonary disease (COPD)

Special Notes _____

6. Vision/Hearing/Speech Conditions

_____None _____ Glaucoma _____ Hard of Hearing _____ Autism
_____ Blind _____ Partially Sighted _____ Deaf _____ Macular Degeneration
_____ Deaf-Blind _____ Night Blindness _____ Diabetic Retinopathy

Special Notes _____

7. Developmental/Mental Conditions

_____None _____ Mood Disorder _____ Autism _____ Psychosis
_____ Thought Disorder

Special Notes _____

8. Is your health condition or disability temporary?

_____ **Yes** How long do you expect it to last? #Years_____ #Months_____
#Weeks_____

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

_____ Since birth #years____

_____ I don't know

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? (Check 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 _____Geri Chair

*** 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 _____Need for Catheter
_____Shortness of Breath _____Dizziness

Special Notes:_____

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

YES NO OCCASIONALLY

**** The customer must provide his or her Personal Care Attendant. The Personal Care Attendant cannot be a registered Paratransit 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:

Name _____
Address _____
City _____ State _____ ZIP _____
Daytime Phone Number (____) _____
Relationship to Applicant _____

I certify to the best of my knowledge the information given above is correct.

Signed _____ Date _____

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 aid 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 Transit that is required to complete this certification, including PART B, and any clarifications required

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by the City of Galesburg Transit.

Clearly print the names of the health care professional who will be certifying your application.

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 Transit.

***Signature of Applicant** _____ **Date:** _____

***MUST BE SIGNED BY APPLICANT PRIOR TO APPROVAL.**

REQUEST FOR PROFESSIONAL VERIFICATION

Dear Health Care Professional:

You are being asked by _____ (**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 Paratransit Curbside Service.

If you have any questions about completing this form or about the transportation provided by the City of Galesburg Transit, please feel free to contact the City of Galesburg Transit office at 345-3686, Monday - Friday between the hours of 8:00 a.m. and 5 p.m.

Thank you for your cooperation

To qualify for Paratransit 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 Paratransit instead of the bus or a taxi, qualify for Paratransit 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 10 DAYS FOLLOWING THE RECEIPT OF THE APPLICATION.

IF YOU HAVE ANY QUESTIONS, YOU MAY CALL THE HANDIVAN OFFICE

PART B - PROFESSIONAL VERIFICATION

**ALL INFORMATION PROVIDED BY THE CLIENT OR THE HEALTH CARE
PROFESSIONAL IS CONFIDENTIAL.**

Paratransit 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:
Specify Mobility Aid _____
3. ____ Arthritis
Specify Extremity _____
4. ____ Amputation
Specify Extremity _____
5. ____ Cerebrovascular Accident _____
6. ____ Pulmonary Ills
Does applicant use a Portable Oxygen Tank? YES NO
7. ____ Neurological Handicap
8. ____ Cardiac Ills
9. ____ Kidney Disease Dialysis ____
10. ____ Sight Disabilities: What **specific** visual impairment does this person have that does not permit them to see well enough to walk to a bus stop? An example would be macular degeneration. Simply being "legally blind" **DOES NOT** qualify the person for paratransit service.

-
-
11. ____ UN coordination
 12. ____ Mental retardation (circle level)
Moderate Severe Profound
 13. ____ Cerebral Palsy
 14. ____ Autism
 15. ____ Severe Muscle Spasms
 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

Describe type and severity of disability in detail and how it prevents use of transit:

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:

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

_____ **Cannot** use regular public transit at all (includes taxis).

PART - PROFESSIONAL VERIFICATION

WHEN DID YOU LAST EXAMINE THIS PATIENT? _____

DID YOU SEE THIS PATIENT PERSONALLY OR DID THE PATIENT SEE JUST THE
NURSE OR PHYSICIAN'S ASSISTANT?

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

D. Your professional area of specialization:

- ☐ Audiologist
- ☐ Psychologist
- ☐ Physical therapist
- ☐ Physician
- ☐ Registered Nurse

THE NAME OF THE PERSON FILLING OUT AND SIGNING THIS VERIFICATION.

NAME: _____

TITLE: _____ AGENCY/COMPANY NAME: _____

PROFESSIONAL LICENSE# (if applicable). _____

OFFICE ADDRESS: _____

OFFICE PHONE NUMBER: _____

I hereby certify that the above information is true. The City of Galesburg Transit office 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 Paratransit Service.

SIGNATURE

DATE