



## “OPERATION UPLIFT”

### ADA PARATRANSIT ELIGIBILITY APPLICATION FORM

In compliance with the Americans with Disabilities Act of 1990 (ADA), the Decatur Public Transit System (DPTS) provides “paratransit” (i.e., van or taxi shared ride) service to anyone with a disability who cannot use DPTS buses and who is traveling in an area served by DPTS fixed route buses. This paratransit van or taxi shared ride service is intended only for those trips that the person cannot make on DPTS buses. This application form is intended to determine when and under what circumstances the applicant can use DPTS buses and when paratransit van or shared service is required. Before completing this application form, please read the enclosed Operation Uplift brochure for more details.

### **INSTRUCTIONS FOR COMPLETING THIS FORM:**

The applicant (or someone assisting the applicant) must complete PARTS 1 through 4. **A licensed physician** must complete and sign the MEDICAL VERIFICATION section.

All applicants, whether new applicants or persons applying for recertification, must complete an application. All questions must be answered. Incomplete forms will be returned. If you have any questions or need assistance completing this form, please call: (217) 424-2821.

#### WHEN COMPLETED, PLEASE RETURN THIS FORM TO:

**Decatur Public Transit System  
353 East William Street  
Decatur, IL 62523  
Fax: (217) 424-2870**

Your application will be reviewed by a committee of Transit System staff members, and you may be asked to come in for a personal evaluation, to better assess your ability to use DPTS’s bus system. You will be notified in writing of the review committee’s decision within 21 days of receipt of the completed application.

- If you have been approved for Operation Uplift, you will be asked to go to the Transit Center to have your photo taken and to pick up your ID card.
- If you have been denied, or approved for only conditional or temporary eligibility, you will be informed of your right to appeal the decision.

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# “OPERATION UPLIFT”

## ADA PARATRANSIT ELIGIBILITY APPLICATION FORM



----- Van and Taxi Program -----

New Application?

Recertification?

### PART 1. GENERAL INFORMATION

PLEASE PRINT

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt: \_\_\_\_\_

Building Complex Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If someone assisted you in completing this form, please identify them below:

Name: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

### PART 2. APPLICANT'S CERTIFICATION

I understand that the purpose of this application is to determine if there are times when, as a result of a disability, I cannot use the bus service provided by **DPTS** and must therefore use the paratransit van or taxi shared ride service. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I certify that, to the best of my knowledge, the information in this application is true and correct. I authorize the medical doctor who provided medical verification to release information relating to the disability to any health professional contracted by **DPTS** to perform eligibility determinations.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For DPTS staff:

Rev. 10/06

Date Application Received for Review: \_\_\_\_\_

### **PART 3. INFORMATION ABOUT THE APPLICANT'S DISABILITY**

1. What type or types of disabilities prevent you from using **DPTS** buses?  
(Check all that apply)

- Physical disability
- Visual impairment/blindness
- Developmental or cognitive disability
- Mental illness
- Other
- None

Please describe your disability in more detail: \_\_\_\_\_

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2. Is the disability described above temporary or permanent?

- Temporary, I expect it to last for another \_\_\_\_\_ months.
- Permanent
- I do not know

3. Does the severity of your disability change from day to day, perhaps because of the weather or medical treatments you receive (i.e. dialysis or chemotherapy)?

- NO
- YES (please explain): \_\_\_\_\_

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4. Please indicate below if you use any of the following mobility aids or equipment:

- Long White Cane
- Alphabet or picture board
- Cane
- Crutches
- Leg Braces
- Walker
- Manual wheelchair
- Electric wheelchair
- Electric scooter/cart
- Other (describe): \_\_\_\_\_
- I do not use any mobility aids or equipment.

NOTE: We may not be able to accommodate you if your wheelchair / scooter is longer than 48 inches or wider than 30 inches, or if your total weight with your wheelchair is more than 600 pounds.

5. If you require a service animal when you travel, please indicate the type of animal: \_\_\_\_\_

6. If you require the assistance of a Personal Care Attendant (PCA) when you travel, please indicate the type of service(s) the PCA is intended to provide:  
\_\_\_\_\_  
\_\_\_\_\_

7. Using a mobility aid or on your own, how far can you travel?

- I cannot go outside my house/apartment
- I can only get to the curb in front of my house/apartment
- I can walk (use wheelchair) up to 1 block
- I can walk (use wheelchair) up to 3 blocks
- I can walk (use wheelchair) up to 6 blocks
- I can walk (use wheelchair) more than 6 blocks

8. What keeps you from traveling further? (Please check all that apply):

- I cannot cross the street if there are no curb-cuts
- I cannot walk (use wheelchair) if the street or sidewalk is too steep
- I cannot cross busy streets and intersections
- I cannot travel outside when it is too hot or too cold
- I cannot find my way at night because of a \_\_\_\_\_ vision problem
- I get confused and cannot find my way
- Other, please explain: \_\_\_\_\_

9. Can you ask for and follow written or oral instructions?

- YES
- NO
- SOMETIMES

If you chose NO or SOMETIMES, please explain: \_\_\_\_\_  
\_\_\_\_\_

10. Can you wait outdoors for up to 30 minutes?

- YES
- YES, but only if there is a place to sit
- YES, but only if it's not too hot or too cold
- NO, please explain: \_\_\_\_\_

\_\_\_\_\_

11. Can you climb three steps with a hand rail without assistance?
- YES
  - NO



#### **PART 4. QUESTIONS ABOUT USING DPTS BUSES**

12. Have you ever used **DPTS** buses?
- YES, I typically use **DPTS** buses \_\_\_\_\_ times a week
  - YES, I used to but stopped because \_\_\_\_\_
  - NO
13. Did you know that all **DPTS** buses and trolleys are wheelchair accessible, and that most of the buses in **DPTS'** active fleet have ramps instead of steps?
- YES
  - NO
14. How does your disability, listed in #1 above, prevent you from using **DPTS** buses?
- \_\_\_\_\_
- \_\_\_\_\_
15. What might help you ride **DPTS** buses? (Check all that apply)
- Travel training to learn how to use the bus system
  - Someone to explain the route and schedule information (help with trip planning)
  - A communication aid (help communicating)
  - Having the bus stops and intersections announced by the driver
  - If the bus stops were closer to where I live and where I need to go
  - None of these would help (please explain): \_\_\_\_\_
- \_\_\_\_\_
16. If someone helped you get on a **DPTS** bus, could you get to a seat or wheelchair position by yourself and ride the bus?
- YES
  - NO (please explain): \_\_\_\_\_
- \_\_\_\_\_
17. If someone helped you get on a **DPTS** bus, would you know where to get off the bus or could you find out by yourself?
- YES
  - NO
  - SOMETIMES

18. If you choose either NO or SOMETIMES in #17 above , check all that apply:

I get confused and cannot remember where I am going

I could if the driver calls out the stops

I probably could with travel signs

Other: (please explain): \_\_\_\_\_

\_\_\_\_\_

19. Please describe any other conditions which limit your ability to use **DPTS** buses, and which you believe make you eligible for “**Operation Uplift**” paratransit van or taxi shared ride service:

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# MEDICAL VERIFICATION

(To be completed by a licensed physician)

<b>PATIENT INFORMATION</b>	NAME: _____
	ADDRESS: _____ _____
	TELEPHONE: _____

The Americans with Disabilities Act of 1990 (ADA) requires that the Decatur Public Transit System (**DPTS**) provide "paratransit" service to anyone who cannot use **DPTS** buses because of a disability. Paratransit services are provided in the Decatur area using private taxicabs and wheelchair lift equipped vans. The person who has asked you to review and sign this application is applying to **DPTS** to be considered eligible for this paratransit service because of a claimed disability.

ADA paratransit van and taxi service is intended only for those trips the person cannot make using **DPTS** buses. This application is intended to help to determine ***when and under what circumstances the applicant can use DPTS buses and when they require paratransit van or taxi service.***

Please carefully review the information provided by the applicant in Parts 2, 3 and 4 of this application and then answer the following questions:

1. Please describe all conditions (physical, cognitive, emotional, other) which functionally prevent the applicant from using **DPTS** buses.  
\_\_\_\_\_  
\_\_\_\_\_
2. How does this condition PREVENT the applicant from using **DPTS** fixed route bus service?  
\_\_\_\_\_  
\_\_\_\_\_
3. Are there any circumstances under which the applicant could use **DPTS** buses? YES \_\_\_ NO \_\_\_  
Please explain: \_\_\_\_\_  
\_\_\_\_\_
4. To the best of your knowledge, is the information provided by the applicant in Parts 2, 3 and 4 of this application true and correct? YES \_\_\_ NO \_\_\_
5. Based on your professional opinion, do you feel that the applicant qualifies for the ADA paratransit van and taxi service? YES \_\_\_ NO \_\_\_

Signature: \_\_\_\_\_  
Print name and title: \_\_\_\_\_  
State of Illinois license # \_\_\_\_\_  
Business address: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

# MEDICAL RELEASE AUTHORIZATION

In order to allow the Decatur Public Transit System to evaluate your request, it may be necessary to contact a physician or other professionals to confirm the information you have provided. Please complete the following information and authorization form.

\* \* \* \* \*

The following Health Care Professional is familiar with my disability and is authorized to provide information to the Decatur Public Transit System.

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_