Rider Application

For Persons aged 18-59

(Consistent with the Americans Disabilities Act)

Washington Urban Area Paratransit Service

This form is to apply for door-to-door paratransit services in specialty equipped vans for residents of the City of Washington Urban Area, Age 18-59. The application will be used by Washington Township, the City of Washington, and the CityLift Mobility Team to determine rider eligibility. All information will remain confidential.

When you complete and return this form **to include your medical professional's signature** and **validation of your qualifying disability for ridership on the back,** you will be notified of your eligibility by U.S. mail or email. With the mail notification, you will receive information about ridership rules, fees, service days and times, etc. If you are denied service, you have the right to appeal the decision regarding your eligibility.

Printed forms are available at City Hall, Washington Township, Washington Library, OSF St. Clare and UnityPoint Washington Clinics. If your disability prevents you from completing the application in this format, please call Washington Township at (309) 444-2987 and ask for assistance.

All completed forms must be returned to Washington Township, 58 Valley Forge Drive, Washington, IL 61571 for processing. Applications are accepted either in person, via U.S. Mail, via Fax to (309) 444-3944, or email to washingtontwp@gmail.com
Questions? Contact Washington Township at Ph. 309-444-2987

Applicant Information

Rider Name: _____ DOB: _____
Last *First* *M.I.*

_____
Street Address *Apartment/Unit#* *City/State*

_____
Mailing Address (if different)

_____ _____
Telephone Number *Email*

_____
Parent/Guardian Name/Phone/Email (If applicable)

_____
Emergency Contact If Different from Above (List supported living contact if applicable) - Name/Phone/Email

Questions:

- I can always recognize my destination and leave the bus. (Check One) ☐YES ☐NO
- I depend upon the driver to announce my destination stop. (Check One) ☐YES ☐NO
- I have a Personal Care Assistant with me. ☐Always ☐Sometimes ☐Never
- Which of the following mobility/ communication aids do you use? (Check all that apply)

☐ Cane ☐Crutches ☐Walker ☐Powered Scooter/ Wheelchair ☐Manual Wheelchair ☐Boarding Chair

☐ Transfer Board ☐Service Animal ☐Communication Aide ☐Portable Oxygen ☐None of these

- If you use a Powered Scooter/Cart/Wheelchair:
  Is it More than 30" wide? ☐ Yes ☐ No
  Is it more than 48" long? ☐ Yes ☐ No
  Is the combined device & occupant over 800 lbs.? ☐ Yes ☐ No
- Do you reside with: (check one)
  ☐ Family ☐ By Yourself ☐ Supported Living (Nursing or Group)

Turn over to complete PAGE 2 of this form.

Pick-up/Drop-off:

For directions related to pick-up and drop-off time and location, notify (list supported living contact, if applicable):

Name: _____ Phone: _____

Relation to applicant: _____

Additional Information:

Is there any other information or special considerations we need to know about you as a rider?

Explain:

IMPORTANT: The following information must be filled out and signed by a medical professional before returning. Applications not signed by a medical professional will not be processed!

Medical Professional Section and Certification

Dear Medical Professional,
Please fill out this brief questionnaire concerning this rider/applicant regarding their specific mobility challenges. It is our intent to offer disability transportation to any person in the Washington Urban area between the ages of 18-59 years of age to points both within the Washington Urban area and to East Peoria and Peoria. There already exists transportation for Individuals 60 years of age and older with mobility challenges. Thank you for your assistance.

Check all that apply:

- ☐ Amputation of extremity(s)
- ☐ Spina Bifida
- ☐ Multiple Sclerosis
- ☐ Quadriplegia/Paraplegia
- ☐ Cerebral Palsy
- ☐ Arthritis of the _____
- ☐ Osteoarthritis of the _____
- ☐ Chronic Pain due to _____
- ☐ Legally Blind with limited mobility
- ☐ Developmental Disability
- ☐ Limited Mobility Due to _____
- ☐ Other Diagnosis or Conditions Impacting Mobility (describe): _____

☐ This condition is Permanent ☐ This Condition is Temporary for (designate length of time): _____

Other Medical Professional comments:

Disclaimer and Signature

As a licensed physician, advanced practiced nurse, physician's assistant, or optometrist, I certify the applicant has a condition that constitutes him/her as a person with mobility disabilities and verifying the nature of the applicant's mobility status I certify that my answers are true and complete to the best of my knowledge.

Medical Professional's Printed Name	Specialty	
Office Address	City, State, ZIP	
Medical Professional's Signature	State Professional's License (Not NPI#)	Today's Date