



**Metro Plus Paratransit  
ELIGIBILITY APPLICATION**

*Form must be filled out completely*

Please Return Completed Form to: River Valley Metro Mass Transit Dist.  
1137 E. 5000 N. Rd.  
Bourbonnais, IL. 60914

**Personal Information**

1. Name \_\_\_\_\_
2. email address \_\_\_\_\_
3. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. Telephone No. (Home) \_\_\_\_\_ (Work) \_\_\_\_\_
5. Date of Birth \_\_\_\_\_

**Certification**

A. I certify that the information I give in this application is true and correct. I understand that falsification of information may result in denial of service. I understand all information will be kept confidential and only the information required to provide the services I request will be disclosed to those who perform those services.

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

B. Person completing form other than applicant (please check one):

- ☐ I certify that the information provided in this application is true and correct, based upon information given to me by the applicant.

- ☐ I certify that the information provided in this application is true and correct, based upon my knowledge of the applicant's health condition or disability.

Exceptions or Additions: \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Agency \_\_\_\_\_

Signature \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Authorization For Release Of Medical/Psychological Records

(Must be completed by applicant, Not Physician)

THIS SECTION IS TO BE COMPLETED BY YOU, THE APPLICANT, AND NOT BY YOUR PHYSICIAN, PSYCHIATRIST OR HEALTH CARE PROFESSIONAL. A SEPARATE FORM MAY BE SENT TO HIM/HER TO CONFIRM THE INFORMATION YOU HAVE PROVIDED.

NOTE: Disability verification by a qualified professional **does NOT guarantee eligibility, but it can play a major role in the eligibility determination process.** While verification by a physician is NOT required, it is important that any professional that verifies another individual's disability be familiar not only with that person's particular disability, but with an individual's ability or inability to travel on Metro's regular bus system. This information is confidential and will NOT be shared with any other person or agency, with the possible exception of another transit provider or transportation program to facilitate travel in those areas.

**NOTE: Only the following professionals are authorized to verify your disability:**

**Licenses Physician, Psychiatrist, Physical Therapist (PT), Occupational Therapist (OTR), Certified Rehabilitation Counselor (CRC), and Orientation and Mobility Specialist (O&M).**

Name of Professional: \_\_\_\_\_

Agency: \_\_\_\_\_

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

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

Telephone Number: \_\_\_\_\_

Name of Professional: \_\_\_\_\_

Agency: \_\_\_\_\_

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

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

Telephone Number: \_\_\_\_\_

**APPLICANT INFORMATION**

NAME (PRINT): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN INFORMATION \***

NAME (PRINT): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**\* NOTE: Applicant signature or Parent/Legal Guardian signature is REQUIRED for application processing.**

## Present Means Of Travel

1. Have you ridden a River Valley Metro's fixed route bus in the last 3 months?

☐ Yes

☐ No

*If No, have you attempted to use a fixed route bus in the last 3 months?*

☐ Yes

☐ No

*If Yes, please explain what happened* \_\_\_\_\_

\_\_\_\_\_

2. What assistance do you need when traveling? *Check all that apply*

\_\_\_\_\_ Support Cane

\_\_\_\_\_ Long Cane/White Cane

\_\_\_\_\_ Service Animal

\_\_\_\_\_ Crutches

\_\_\_\_\_ Wheelchair (Power)

\_\_\_\_\_ Walker

\_\_\_\_\_ Need help transferring to a seat

\_\_\_\_\_ Electronic Travel Aid

\_\_\_\_\_ Personal Care Attendant

\_\_\_\_\_ Powered Scooter

\_\_\_\_\_ Prosthesis

\_\_\_\_\_ Wheelchair (Manual)

\_\_\_\_\_ None

\_\_\_\_\_ Other \_\_\_\_\_

If you use a wheelchair or scooter/cart, is it

\_\_\_\_\_ More than 30 inches wide OR

\_\_\_\_\_ More than 48 inches long, OR

\_\_\_\_\_ Weigh more than 600 pounds when empty?

3. Do you require a Personal Care Attendant (PCA)\* when you travel?

☐ Always

☐ Sometimes

☐ Never

*If Always or Sometimes, provide name of PCA:*

\_\_\_\_\_

*\* A PCA is someone designated or employed by a person with a disability to assist that person in meeting his or her personal needs and/or to facilitate travel for a specific trip. A PCA is not a companion.*

### Transit Travel/Training Information

1. Do you know where to get off the bus, or can you find out?

☐ Always

☐ Sometimes

☐ Never

*If Sometimes, please explain.* \_\_\_\_\_

2. Have you ever had any training to use the fixed route bus service?

☐ Yes

☐ In Process

☐ No

### Disability and Functional Limitation Information

1. Please describe your current disability (list all applicable disabilities).

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2. Is your health condition or disability temporary?

☐ Yes

☐ No

*If Yes, expected end date* \_\_\_\_/\_\_\_\_/\_\_\_\_ *or* (\_\_\_\_ months)

3. Does your health condition or disability change from day-to-day in ways that affect your ability to use the fixed route bus service?

☐ Yes

☐ No

*If Yes, please explain* \_\_\_\_\_

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4. Are there any other conditions (such as extreme hot or cold weather) that limit your ability to use the fixed route bus service?

☐ Yes

☐ No

*If Yes, please explain* \_\_\_\_\_

\_\_\_\_\_

5. Can you transfer from one fixed route bus to another?

☐ Yes

☐ Sometimes

☐ No

*If Sometimes or No, please explain* \_\_\_\_\_

\_\_\_\_\_

6. Can you use the telephone or TTY to make calls?

☐ Yes

☐ Sometimes

☐ No

*If Sometimes or No, please explain* \_\_\_\_\_

\_\_\_\_\_

7. Can you follow instructions?

WRITTEN INSTRUCTIONS: ☐ Yes ☐ Sometimes ☐ No

VERBAL INSTRUCTIONS: ☐ Yes ☐ Sometimes ☐ No

*If Sometimes or No, please explain* \_\_\_\_\_

\_\_\_\_\_

8. Are you able to make your way to and from the nearest bus stop to your home, either with or without mobility aids?

☐ Yes

☐ Sometimes

☐ No

*If Sometimes or No, please explain* \_\_\_\_\_

\_\_\_\_\_

9. Can you wait outside for 15 minutes?

☐ Yes

☐ Sometimes

☐ No

Explain if Sometimes or No \_\_\_\_\_

\_\_\_\_\_

10. Are you able to travel  $\frac{1}{4}$  mile (4 blocks or less), either with or without mobility aids?

☐ Yes

☐ Sometimes

☐ No

Explain if Sometimes or No \_\_\_\_\_

\_\_\_\_\_

11. If using a wheelchair, are you able to transfer from the chair to a bus seat?

☐ Yes

☐ No

If Yes describe limitations: \_\_\_\_\_

<b>Miscellaneous</b>
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1. Check all that apply if you are NOT currently riding fixed route buses:

\_\_\_\_\_ I don't know how to ride the regular fixed route bus.

\_\_\_\_\_ I'm afraid to ride the regular fixed route bus.

\_\_\_\_\_ I don't want to ride the regular fixed route bus.

\_\_\_\_\_ It is too far to get to the regular fixed route bus.

\_\_\_\_\_ The ground is too uneven or steep for me to get to the bus stop.

\_\_\_\_\_ There are no sidewalks where I live.

\_\_\_\_\_ I need a wheelchair lift or ramp to board the bus.

\_\_\_\_\_ I can use the regular fixed route bus under certain circumstances.

\_\_\_\_\_ I cannot recognize a destination or landmark.

\_\_\_\_\_ Other (Please explain) \_\_\_\_\_

2. Are there any other aspects of your health condition or disability that we should know about?

☐ Yes

☐ No

If Yes, please explain \_\_\_\_\_