City of DeKalb
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Application for Paratransit & Non-Emergency Medical Transportation Services

***Please read, sign, date, and mail to* Transdev *Eligibility Department,* 1825 Pleasant St, DeKalb, IL 60115.**

All **new** applicants must meet the senior citizen or individual with disability standards to be considered eligible for the paratransit and non-emergency medical transportation (NEMT) services. A senior citizen is classified as an individual of age 65 and older. All individuals that submit applications on and after January 1, 2021 must provide a copy of their State of Illinois issued identification card that clearly states that the person has a disability or is 65 years of age or older.
A new applicant who is not 65 years or older or does not have a disability or health condition that may prevent them from using the fixed route system will be unable to utilize the paratransit and non-emergency medical transportation (NEMT) services.

Applications for individuals who are under the age of 18 years must be completed by the applicant's parent, legal guardian, or custodian. If an applicant is 18 years or older but is unable to complete the application because of a physical or vision impairment, the applicant must have given permission to the person completing the application. Applications for individuals 18 years of age or older with cognitive impairments may be completed by the applicant's legal guardian or custodian.

Applications that do not meet the above criteria will not be processed. Thank you in advance for your cooperation.

Section 1: *Personal Data* **Check One:** New Applicant ☐ Existing Customer ☐

Applicant Name: ______________________________ Prefix: (Mr/Ms/Mrs/Dr – Circle One)

Date of Birth: ____________________ E-Mail Address: ______________________________

Address: ____

City: ______________________ State: ____________________ Zip: ________________

Home Phone Number: ________________________ Cell Phone Number: ________________________

I would like to receive SMS Text Message Alerts Yes ☐ No ☐

Primary Language: ____

Section 2: *Disability Information*

1. Which **disability or health related conditions prevent** you from using the Huskie Line fixed route bus service?

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2. Briefly explain **how** your condition prevents you from using the Huskie Line bus service.

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3. Do the conditions you described change from day to day in a way that affects your ability to use public transit?

☐ Yes, good on some days, bad on others ☐ No, does not change. ☐ Don't know.

4. Are the conditions described:

☐ Permanent ☐ Temporary ☐ Don't know

If temporary, how long do you expect the condition(s) to continue?

____

5. Do you use any of the following mobility aids or specialized equipment? (Check all that apply):

☐ Cane ☐ Power Wheelchair ☐ Communication Devices

☐ White Cane ☐ Service Animal ☐ Walker

☐ Power Scooter ☐ Crutches ☐ Manual Wheelchair

☐ Leg Braces ☐ Portable Oxygen Tank

☐ Other Aid: ____

6. Please check the box that best describes your current living situation:

☐ 24 Hour Care or Skilled Nursing Facility

☐ Assisted Living Facility

☐ I receive assistance from someone that comes to my home to help with daily living activities.

☐ I live with family members who help me

☐ I live independently without the assistance of another person

7. Are you able to get to and from the Huskie Line bus stop nearest your home?

☐ Yes ☐ No ☐ Sometimes

If no or sometimes, please explain why: ____

____

8. Which of the following statements best describes you?
(Check only one response):

☐ I have never used the Huskie Line bus system.

☐ I have used the Huskie Line bus system but not since the onset of my disability.

☐ I have used the Huskie Line bus system within the past 12 months.

9. Do you travel with the help of another person?

☐ Always ☐ Sometimes ☐ Never

If "always" or "sometimes", what type of help do they provide? ____________________________________

10. Please add any other information that you would like us to know about your abilities.

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11. Do you need written information provided to you in an accessible format?

☐ Yes ☐ No

If yes, please describe: ____

Section 3: Applicant Certification (Please sign)

All applicants must sign the completed application. If this application has been completed by someone other than the person requesting certification, the person who completed the application must provide the following information:

Name of Applicant: ____

Address: ____________________________________ Phone Number: _________________________

City: _________________________________ State: _____________ Zip Code: __________________

Signature: _____________________________________ Date: __________________________________

Name of Person Assisting Applicant: ____

Relationship to Applicant: ____

Emergency Contact Name: _____________________________ Relationship: _______________________

Address: ____________________________________ Phone Number: __________________________

City: ________________________________ State: _____________ Zip Code: ___________________

By signing this application, you are certifying under penalty of perjury under the laws of the State of Illinois that the foregoing is true and correct.

Applicant/Legal Guardian Signature: __________________________________ Date: _________________

Please Note: a licensed Medical or Mental Health Provider, one who is **most** familiar with you and your disability/limiting condition, may be required to complete a Professional Verification form if an eligibility determination cannot be made based upon the information provided on this application.

Revised: May 17, 2021

Professional Verification

Applicant Name: ____

Thank you for completing this Professional Verification form for City of DeKalb paratransit services. We will use the information to help determine paratransit eligibility in accordance with the Americans with Disabilities Act (ADA). Paratransit is a shared ride, public transportation service for individuals who, because of the effects of their disabilities/limiting conditions, are not able to ride a regular ramp-equipped and accessible fixed route bus. **Age, language, convenience of the service, fear of falling, inability to drive, and inability to carry packages are not qualifying factors for paratransit service**. Please call the City of DeKalb's contracted paratransit provider, Transdev, at 815-420-5500 if you have any questions.

Please review the information provided by the applicant on this application form. Based on your knowledge of the applicant's condition, is the information accurate? ☐ Yes ☐ No ☐ Somewhat

If you checked *No* or *Somewhat*, please explain:

____

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Are there any changes or additions you would make to the list of stated Diagnosis/Disability shown on page 1, Section 2 of this application?

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Please provide any additional information that you deem relevant as to why the effects of the applicant's disability/limiting condition will prevent their use of the regular, fixed route bus system?

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I am an approved provider, licensed in the State of Illinois in the field indicated below, and certify that the above-mentioned individual has the disability and limitations indicated above.

____	________________________
Professional Care Provider's Signature	Date
____	________________________
Professional Care Provider's Name (Please Print)	Phone
____	________________________
Mailing Address	Clinic/Agency Name

____

Individual National Provider Identifier (NPI)

***This form considered incomplete without a valid <u>individual</u> number.**

Revised: May 17, 2021