Central Transportation
2700 Week Street
Stevens Point WI 54482

Point Plus Eligibility Application

Specialized Transportation Certification

The information obtained in this certification will only be used for the provision of Central Transportation specialized transportation services.

Last Name _____ First Name _____ M.I. _____

Address _____ Name of facility (if applicable) _____

City _____ State _____ Zip _____

Date of birth _____/_____/_____ Gender : ☐ Male ☐ Female

Telephone # (Home) _____ Cell # _____

Emergency contact:

Last Name _____ First Name _____ Relationship _____

Telephone # (Home) _____ Cell # _____

1. Are you on Medical Assistance? ☐ Yes ☐ No
   (Otherwise known as Medicaid, Title XIX or MA-not to be confused with Medicare)

2. Are you a member of any of the following social service agencies? ☐ Yes ☐ No

   If "Yes" please specify: ☐ Inclusa ☐ Care Wisconsin ☐ IRIS ☐ MTM

3. Please check which best describes your current living situation:

   ☐ I live independently (without the assistance of another person)
   ☐ I live with family members who help me
   ☐ I receive assistance from someone that comes to my home to help with daily activities
   ☐ Assisted Living Facility
   ☐ 24-hour care or Skilled Nursing Facility

4. What is your disability or medical condition that prevents you from using the city bus?

   _____

   _____

5. Is this condition temporary? ☐ Yes ☐ No

   If "Yes", expected duration is: ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months

6. Which of the following mobility aids do you use? **Please check all that apply.**

   ☐ Manual Wheelchair ☐ Electric Scooter ☐ White Cane ☐ Cane
   ☐ Electric Wheelchair ☐ Portable Oxygen ☐ Guide Animal ☐ Crutches ☐ Walker

7. How far can you travel with or without the use of a mobility aid?

- ☐ I cannot travel outside my house/apartment
- ☐ I can get to the curb in front of my house/apartment
- ☐ I can travel up to 3 blocks
- ☐ I can travel up to 6 blocks

8. How do you currently travel?

☐ Drive myself ☐ Paratransit ☐ Someone drives me

☐ Taxi ☐ City bus ☐ Other

If "Other", please explain: _____

9. Do you travel with a Personal Care Attendant? ☐ Yes ☐ No

10. Can you wait outside at a bus stop for 10-15 minutes? ☐ Yes ☐ No ☐ Sometimes

11. If you use a mobility device (i.e. wheelchair or scooter) can you get on and off a wheelchair lift independently? ☐ Yes ☐ No

12. Is your ability to travel affected by any physical, or natural barriers (distance, terrain, weather, lack of curb ramps, etc.)? ☐ Yes ☐ No

If "Yes", please explain: _____

13. Place an (**X**) in the box if it describes you. **Please check all that apply.**

- ☐ I have a disability which prevents me from boarding the city bus.
- ☐ I have a disability which prevents me from getting to a bus stop.
- ☐ I have no experience with the city bus.
- ☐ There is no bus stop near my residence.

14. Place an (**X**) in the box if it describes you. **Please check all that apply.**

- ☐ I can read informational signs.
- ☐ When I travel, I can find my way around by myself.
- ☐ I can ask, understand and follow directions.

15. If personalized travel training was provided to teach you how to ride the city bus, would you be willing to participate? ☐ Yes ☐ No

The Americans with Disabilities Act (ADA) requires public transportation programs to service those individuals in a mobility device <u>if</u> the lift and vehicle can physically accommodate the passenger. If accommodations become inconsistent with legitimate safety requirements, the ADA does not guarantee your trip. This clause is observed by all specialized and non-specialized transportation services provided by Stevens Point Transit.

Professional Verification

In order for your application to be evaluated, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and authorization form:

The following professional(s) is/are most familiar with my disability/health condition and is/are authorized to provide Stevens Point Transit with the information required to complete this certification.

☐ Registered Nurse ☐ Case Manager ☐ Rehabilitation Professional
☐ Physical Therapist ☐ Occupational Therapist ☐ Mental Health Professional

Professional(s) Name: _____Facility:_____

Address: _____City: _____State: _____Zip:_____

Telephone Number: _____ Fax Number: _____

I hereby authorize the above professional to provide the required information to Stevens Point Transit. Furthermore, I understand it may be necessary for me to participate in an in-person evaluation to determine my eligibility for specialized transportation services. I certify that the information may result in denial of service.

Signed: _____ Date: _____
(Signature of Applicant or Legal Guardian)

Billing Information (check appropriate box)

☐ **Facility is responsible for all rides**
☐ **Facility is responsible for medical rides only**

Name of Facility _____

Address _____ City _____ State _____ Zip _____

Telephone # _____

I have read and understand I am responsible for paying all invoices incurred by this applicant. Payment is due within 30 days of receipt.

Signed: _____ Date: _____
(Signature of Responsible Party)

☐ **Applicant is responsible for payment**

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Telephone # _____

Applicant must pay at the time of the ride or establish a prepaid account.

Signed: _____ Date: _____
(Signature of Responsible Party)

Acknowledgement

To the best of my knowledge the above information is true and factual. I understand that falsification, distortion, or misrepresentation of information may result in denial of service.

Signed: _____ Date: _____
(Signature of Applicant or Legal Guardian)

If this application has been completed by someone other than the person requesting certification, he/she must supply the following information about him/herself:

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Please mail or fax completed application to:

Central Transportation
2700 Week Street
Stevens Point WI 54482
Fax: 715-345-5375

Please note you will be contacted via telephone if you need to be evaluated in person. All applicants will receive a letter within 21 days of receipt of the completed application with a determination. If you are denied, the appeals process will be provided.

For Office Use Only:

In-person Review Required: □ Yes □ No **In-person Review Completed:** □ Yes □ No **Date** _____

Doctor's Verification Required: □ Yes □ No **Doctor's Verification Received:** □ Yes □ No

Eligibility: □ Conditional □ Unconditional □ Temporary - expected duration is _____

Date Received _____ **Date Approved**_____ **Initials** _____