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County Executive

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Manager



**AGING AND DISABILITY RESOURCE CENTER  
OF WAUKESHA COUNTY  
A Division of Health and Human Services**

**ELIGIBILITY APPLICATION for the  
TAXI and RIDELINE SPECIALIZED TRANSPORTATION PROGRAMS**

**Taxi Program**

For Waukesha County residents, who are non or limited drivers, age 65 years or older, and able to enter or exit an automobile with little or no assistance.

AND Waukesha County residents, who are non-drivers between 18 and 65, able to enter or exit an automobile with little or no assistance **and** receive either SSI or SSDI benefits. A SSI or SSDI Benefits Verification Form must be submitted with application and can be obtained from:

Social Security Office  
707 North Grand Avenue  
Waukesha, WI 53186  
866-220-7885 or 1-800-772-1213

**RideLine Program**

For Waukesha County residents, who are non or limited drivers, age 65 years or older, unable to enter or exit an automobile and require an accessible vehicle, or have no taxi service in their community, or need to travel outside of the taxi service area.

AND for those Waukesha County residents who are non-drivers under the age of 65 years, unable to enter or exit an automobile and use either a wheelchair, scooter, cane, walker, crutches, or are legally blind.

Service to Milwaukee County ONLY for second opinions, consultations, or service NOT duplicated in Waukesha County with prior approval.

**Please mail your completed application to:**

**Aging and Disability Resource Center of Waukesha County  
Human Services Center  
500 Riverview Avenue  
Waukesha, WI 53188**

**Or fax application to (262-896-8273) Local: (262)548-7848 (866) 677-2372**

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**Privacy Policy**

The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information may be shared with the transportation providers that the ADRC contracts with for transportation services. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. Failure to provide this information may result in a denial of some services. If you have questions regarding this, please ask the Aging and Disability Resource Center staff.

**RideLine & Local Shared-Fare Taxi  
APPLICATION FORM**

Information provided on this application will be kept confidential and used by the Aging and Disability Resource Center of Waukesha County for determining eligibility for the specialized transportation programs. **If you need assistance filling out this form, call the Aging and Disability Resource Center at (262) 548-7848. PLEASE PRINT**

Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  F  M  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City/Village/Town \_\_\_\_\_ Zip \_\_\_\_\_  
Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_\_

Please provide name, age and relationship of those living with you. \_\_\_\_\_

1. Are you receiving Medicaid (Title 19)?  Y  N

If yes....Forward Health # \_\_\_\_\_

2. Are you receiving publicly funded long-term care assistance?  Y  N

If yes, which one?  Care Wisconsin  Community Care  IRIS  
 PACE  Partnership

3. Are you applying for taxi, 18-65 years of age, and receiving SSI or SSDI?  
 Y  N If yes, submit an SSI or SSDI Benefits Verification Form  
with your application.

4. Are you able to enter and exit a vehicle with little or no assistance?  Y  N

5. Is your disability or limitation temporary?  Y  N

6. Is your disability or limitation due to an accident or work-related injury?  Y  N  
If yes, is there an active claim with an insurance company?  Y  N

7. Do you use any of the following aides?  Y  N

If yes, check all that apply:

- |  |                                   |   |               |
|--|-----------------------------------|---|---------------|
| <input type="checkbox"/> legally blind       | <input type="checkbox"/> walker   | <input type="checkbox"/> manual wheelchair  | If oversized: |
| <input type="checkbox"/> white cane          | <input type="checkbox"/> crutches | <input type="checkbox"/> powered wheelchair | length _____  |
| <input type="checkbox"/> service animal      | <input type="checkbox"/> cane     | <input type="checkbox"/> scooter            | width _____   |
| <input type="checkbox"/> portable oxygen     |                                   |   |               |
| <input type="checkbox"/> orthotic/prosthetic |                                   |   |               |
- Are you able to transfer to a seat with little or no assistance  Y  N

**Check all that apply:**

**Non-ambulatory:**  
requires permanent use of a wheelchair

**Respiratory Impairment:**  
occurs when climbing steps or walking

**Pacemaker:**  
condition interferes with independent mobility

**Cardiac Disease:**  
resulting in marked limitation of physical activity

**Restricted Mobility:**  
condition causes difficulty walking; requires the use of a mobility aid

**Nerve Root Compression Syndrome:**  
causes pain and motion limitation in back or neck

**Arthritis:**  
Causes a functional motor defect in any two major limbs

**Dialysis:**  
requires use of kidney dialysis machine and causes post-treatment weakness

**Diabetes:**  
Condition status interferes with independent mobility

**Spinal Disorders:**  
causes motor and sensory loss, osteoporosis with pain, limit of movement

**Visual Impairment:**  
interferes with independent mobility; legally blind

**Mental or Emotional Impairment:**  
interferes with independent mobility

**Hearing Impairment:**  
interferes with independent mobility

**Chemotherapy or Radiation:**  
causes post-treatment weakness

**Speech Impairment:**  
interferes with independent mobility

**Developmental Disabilities:**  
interferes with independent mobility

**Aging:**  
limitations to mobility due to advanced age with fatigue and decreased energy level; restricted mobility and slowed response time;

**Amputation of**  
**LEG:**  *right*  *left*  
**ARM:**  *right*  *left*

**Autism:**  
interferes with independent mobility

**Neurological Impairment:**

- Cerebral Palsy
- Multiple Sclerosis
- Muscular Dystrophy

- Traumatic Brain Injury
- Parkinson's Disease
- Memory Loss or Dementia

- Epilepsy
- Seizure Disorder
- Other \_\_\_\_\_

**Comments:**

For **RideLine** applicants, an “attendant” is defined as “a personal aide to the passenger, necessary to facilitate the safe mobility of the passenger.” In a very real sense, **if an attendant is deemed necessary** to provide mobility assistance or supervision to ensure safety beyond the basic door-to-door service provided by the RideLine program, **all travels will require an attendant and no rides can be arranged without one.**

Do you require a personal attendant when you travel?  Y  N

If someone other than the applicant will be arranging trips, provide his/her name and phone number:

Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Emergency Contact Information

Provide information on *at least two* persons to be contacted in case of emergency

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

**Primary Physician Name:** \_\_\_\_\_

**Office Address/City/Zip:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_

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I believe the information provided in this application is true and correct. I understand that deliberately providing false information is punishable by law and may jeopardize the receipt of services. I hereby authorize the Aging and Disability Resource Center to verify the information in this application.

**\*Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Application being completed by a person other than the applicant,  
please complete the following:**

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

Agency Affiliation (if appropriate) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone (\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Aging and Disability Resource Center of Waukesha County  
RIDELINE FARE DETERMINATION FORM**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Do you receive Title 19?  Y  N Do you receive Long-Term Care funding?  Y  N

**If you receive Title 19 or Long-Term Care Funding, do not complete the remainder of this page.**

**Choose OPTION A or OPTION B if you do not receive  
Title 19 or Long-Term Care Funding**

**OPTION A:** I do not wish to divulge my financial information. I agree to pay the following fare:

One-way trip within the same community:	\$ 8.00
One-way trip from one community to another	\$10.50
One-way trip to an adjoining County (available ONLY for medical and ONLY if service is NOT available in Waukesha County):	\$17.00

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OPTION B:** I have listed my financial information for the Aging and Disability Resource Center of Waukesha County. The information will be used to determine my RideLine fares based upon my ability to pay.

	<i>Passenger</i>	<i>Spouse</i>
1) Average Monthly Income:	\$ _____	\$ _____
2) Average Monthly Medical Expenses	\$ _____	\$ _____
3) Total Liquid Assets:	\$ _____	\$ _____

1) **Average Monthly Income:** include your social security, pension, disability, wages, interest/dividends, rental income, and any other income you may receive.

2) **Average Monthly Medical Expenses:** include medicine, medical supplies, health insurance premiums, and dental, doctor or hospital bills. DO NOT INCLUDE medical expenses paid for by Medicare, Medicaid, or other insurance.

3) **Total Liquid Assets:** include savings, checking, CDs, stocks, bonds, trusts, and annuities.

This information is true and complete to the best of my knowledge. I authorize the use of this information by representatives of the Aging and Disability Resource Center of Waukesha County for the purposes of fare determination. I understand this information will remain confidential.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return this completed form to:** Aging and Disability Resource Center of Waukesha County  
Human Services Center  
500 Riverview Avenue  
Waukesha, WI 53188

OR FAX TO (262) 896-8273