



Waukesha County

Department 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** are **able** to enter or exit an automobile with little or no assistance.

Waukesha County residents, who:

- Are non- or limited drivers between 18 and 64;
- **AND** Are **able** to enter or exit an automobile with little or no assistance;
- **AND** have completed the Disability Designation Form by their physician (last page of application), or are determined disabled by the Social Security Administration, Railroad or Federal Government Disability Determining Board.

A form of disability verification must be submitted with application for those 18-64 years of age.

RideLine Program

For Waukesha County residents, who:

- Are non- or limited drivers, age 65 years or older;
- **AND** are **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.

Waukesha County residents who:

- Are non- or limited drivers under the age of 65;
- **AND** have a disability designation and are unable to enter or exit an automobile and use either a wheelchair, scooter, cane, walker, crutches or are legally blind;
- **OR** have no taxi service in their community or need to travel outside of the taxi service area.

RideLine Service to surrounding counties is ONLY available for second opinions, consultations, or service NOT duplicated in Waukesha County. Prior approval is required.

Please **mail** your completed application to:

**AGING AND DISABILITY RESOURCE CENTER OF WAUKESHA COUNTY
HUMAN SERVICES CENTER
514 RIVERVIEW AVENUE
WAUKESHA, WI 53188-3631**

Or fax your application to: (262) 896-8273

If you have any questions, please call (262) 548-7928 or (866) 677-2372

RideLine & Local Shared-Fare Taxi APPLICATION FORM

Information provided on this application will be kept confidential and will only be 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) 548-7928. PLEASE PRINT**

I am applying for:

- Taxi (Complete Page 1, sign & date) RideLine (Complete pages 1-3, sign & date)
 Taxi & RideLine (Complete pages 1-3, sign & date)

Name _____
 Date of Birth _____ Age _____ F M
 Permanent 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 ID Number _____

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

If yes, which one? Family Care IRIS PACE Partnership

3. Are you under 65 and applying for taxi? Y N

If you are applying for taxi and are 18-64 years of age, you must have a disability determination to qualify. A Disability Designation Form (see last page of this application) or a Benefits Verification Form is required to process your application for Taxi service.

4. Is your disability or limitation temporary? Y N

5. 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

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

Are you able to transfer to a seat with little or no assistance? Y N

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

If yes, check all that apply:

- | | | | |
|--|-----------------------------------|---|--|
| <input type="checkbox"/> white cane | <input type="checkbox"/> walker | <input type="checkbox"/> manual wheelchair | If oversized: length _____ width _____ |
| <input type="checkbox"/> service animal | <input type="checkbox"/> crutches | <input type="checkbox"/> powered wheelchair | |
| <input type="checkbox"/> portable oxygen | <input type="checkbox"/> cane | <input type="checkbox"/> scooter | |
| <input type="checkbox"/> orthotic/prosthetic | | | |

Signature of Applicant: _____ Date: _____

If Applying for RideLine, please complete both sides:

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. Rider is responsible to provide, or arrange for, their own attendant.**

Do you have a personal attendant who is required to accompany your travel? Y N

Rider must provide or arrange for personal attendant

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: _____

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.

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:** _____

If this application has been 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
 Please complete sections 1 and 2, sign & date**

1. 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.

2. 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: | \$ 8.55 |
| One-way trip from one community to another | \$11.15 |
| One-way trip to an adjoining County (available ONLY with prior approval for medical and ONLY if service is NOT available in Waukesha County): | \$17.90 |

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, supplemental 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, IRAs, 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
 514 Riverview Avenue
 Waukesha, WI 53188-3631 OR FAX TO (262) 896-8273

RideLine & Local Shared-Fare Taxi DISABILITY DESIGNATION FORM

Information provided on this application will be kept confidential and will only be 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) 548-7928.**

PLEASE PRINT

Name of Applicant (please print) _____

Date of Birth _____ F M

Address _____ City _____ Phone _____

TO BE COMPLETED BY PHYSICIAN

This is to certify that _____ has a physical, mental or other
(Applicant's Name)
disability that requires specialized transportation. This disability is (circle one) PERMANENT /
TEMPORARY. If temporary, this person will require specialized transportation from the period
beginning _____ and ending _____.

An attendant is required for this person while traveling (circle one) YES NO

I certify that to the best of my knowledge the information contained on this form is true and correct.

PRINT NAME _____ DATE _____

SIGNATURE _____ NPI or Tax ID # _____

TITLE _____ AGENCY NAME _____

Address _____ City _____ Zip _____ Phone _____

Please return this completed form to:
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Human Services Center
514 Riverview Avenue
Waukesha, WI 53188-3631 OR FAX TO (262) 896-8273