



# 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.

OR Waukesha County residents, who:

- Are non-drivers between 18 and 65; and
- Are able to enter or exit an automobile with little or no assistance; and
- 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 and can be obtained from the Social Security Office: 707 N. Grand Avenue, Waukesha, WI 53186, phone: 1-866-220-7885 or other disability determining bureau.

#### **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.

AND for those Waukesha County residents who:

- Are non-drivers under the age of 65; and
- Are unable to enter or exit an automobile and use either a wheelchair, scooter, cane, walker, crutches or are legally blind.

RideLine Service to Milwaukee County 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?  Care Wisconsin  Community Care  IRIS  
 PACE  Partnership  MCDFC  ContinuUs

3. If you are applying for taxi and are 18-65 years of age, you must have a disability determination to qualify. Are you applying for taxi?  Y  N  
If yes, a Disability Verification Form or a Benefits Verification Form is required to process your application for Taxi service.

4. 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

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 aids?  Y  N  
If yes, check all that apply:

- |  |                                   |   |                              |            |
|--|-----------------------------------|---|------------------------------|------------|
| <input type="checkbox"/> legally blind       | <input type="checkbox"/> walker   | <input type="checkbox"/> manual wheelchair  | If oversized:<br>length_____ |            |
| <input type="checkbox"/> white cane          | <input type="checkbox"/> crutches | <input type="checkbox"/> powered wheelchair |                              |            |
| <input type="checkbox"/> service animal      | <input type="checkbox"/> cane     | <input type="checkbox"/> scooter            |                              | width_____ |
| <input type="checkbox"/> portable oxygen     |                                   |   |                              |            |
| <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.**

Do you have a personal attendant who is required to accompany 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:** \_\_\_\_\_

**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:	\$ 8.30
One-way trip from one community to another	\$10.90
One-way trip to an adjoining County (available ONLY with prior approval for medical and ONLY if service is NOT available in Waukesha County):	\$17.65

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