Application Instructions for Paratransit Eligibility

What is Transit Plus?

Transit Plus is the program that provides paratransit services for Milwaukee County. The goal of Transit Plus is to provide public transportation for people with disabilities who are unable to use the fixed route Milwaukee County Transit System (MCTS) buses all or some of the time.

How is eligibility determined?

To determine eligibility, we consider your functional ability and whether you are able to travel on MCTS buses all or some of the time. We do not base eligibility on symptoms, type of disability, use of a mobility aid, age, income, ability to drive, or access to private automobile transportation.

How do I apply for Transit Plus?

The process includes completion of the application and an in-person assessment. We must receive ***the entire completed application*** before we set up an assessment appointment. Please use the checklist on the back of this page to ensure that your application is completed properly. After completion of the application and the in-person assessment, your eligibility will be determined within 21 days. If Transit Plus is unable to make an eligibility determination within 21 days, presumptive service will be provided to the applicant beginning on the 22nd day as if eligibility has been granted. Service may be terminated if Transit Plus later denies the application.

- **Do not request or authorize a doctor's office to fax anything to us. We no longer accept faxed applications.**

- **Do not separate Parts 1, 2,3, and 4. Please submit the entire completed application.**

Important notes on Part 4:

- **Part 4 must be filled out by a licensed healthcare provider**. The form is valid for 90-days from the date of the provider's signature.
- Do not detach Part 4.
- If you or another non-licensed healthcare provider fill out Part 4, your application will be invalid.
- If you skip any part of the application, we cannot determine your eligibility. Incomplete forms will be returned to sender unprocessed.
- Do not request or authorize a medical office to send documents separately to Transit Plus.
- Additional medical documentation is allowed, but do not use as a substitute for Part 4.

How do I submit my application?

Your application can be submitted in any of the following ways:

U.S. Postal Service:
Transit Plus
1942 N 17th Street
Milwaukee, WI 53205

E-mail:
TPlusApplications@mcts.org

In-Person:
8:30am – 4:00pm
at the Transit Plus Office
1942 N 17th Street
Milwaukee, WI 53205

After Transit Plus receives your correctly completed application, you will be contacted with available appointment times. **Any applicant who may require personal care/toileting assistance or behavioral supervision must be accompanied by a caregiver or family member.**

Application Checklist

1. Complete Parts 1, 2, and 3 of the Eligibility Application

- ☐ I filled out Parts 1, 2, and 3 completely.
- ☐ I provided my current contact information.
- ☐ I signed the form.

2. Ask your authorized licensed healthcare provider to complete Part 4

- ☐ I gave the complete application (Parts 1, 2, 3, and 4) to my medical provider.
- ☐ My provider completed Part 4 and returned all parts to me.
- ☐ I verified that Part 4 was completed in full, signed, and dated.

3. Review the application

- ☐ I made sure that all questions have answers and all portions needing a signature are signed by the correct person.
- ☐ I have attached any additional materials provided by my health care provider (if applicable).
- ☐ I understand that Transit Plus processes applications in the date order received and that all parts of the application must be **complete** or it will be returned to me.

4. Make a copy for your records

- ☐ I copied my complete application for my personal records. Transit Plus will not provide a copy.

5. Submission of application

- ☐ I submitted my application in one of the following ways:
  - By mail to 1942 N. 17th St. Milwaukee WI 53205.
  - In-person between 8:30 am and 4:00 pm.
  - By E-mail to TPlusApplications@mcts.org.

6. Assessment appointment scheduling

- ☐ I understand that after my completed application has been reviewed by Transit Plus staff, I will be contacted to schedule an assessment appointment.

Application for Paratransit Eligibility Certification

Part 1: APPLICANT IDENTIFICATION

Name (PRINTED): _____
Last First M.I.

Are you a current or past Transit Plus client? ☐ Yes ☐ No

If "YES" write the Expiration Date: _____ and Client ID number: _____

What is the preferred method of contact to schedule the in-person assessment?
☐ Phone number (as printed below) ☐ E-mail address (as printed below)

Phone Number(s): _____
Cell Phone (Primary) Home Phone (Secondary)

E-Mail Address: _____

D.O.B.: _____ Age: _____ SSN: _____ Gender: _____

Address: _____ Apt. #: _____

City, State, Zip: _____
City State Zip Code

Provide information for the person we should contact in an emergency:

Emergency Contact Name: _____

Relationship to Applicant: _____

Phone Number(s): _____
Primary Phone Secondary Phone

Where should we send future information? ☐ To me, the Applicant ☐ To Designee below:

Name of Information Designee: _____

Address of Information Designee: _____

E-Mail Address of Designee: _____

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Part 2: ASSISTIVE DEVICE INVENTORY

1. I use the following assistive devices all or some of the time: *(mark all that apply)*

☐ Cane ☐ Crutches ☐ Walker/ Rollator ☐ Prosthesis ☐ Portable Oxygen

☐ Service Animal ☐ Manual Wheelchair ☐ Extra wide wheelchair (> 30 in wide)

☐ Motorized Wheelchair/Scooter ☐ None ☐ Other _____

** Please note, if you marked "Wheelchair or Scooter" above; individuals using mobility devices that exceed 30" in width and/or 48" in length (measured 2" above the ground) may not be able to be accommodated. Also, in situations where the applicant and their mobility device have a combined weight of more than 600lbs when occupied; may not be able to be accommodated.*

2. Which of the following best describe your current living arrangement?

☐ Private Home/Apartment ☐ Rehab Facility ☐ Assisted Living/Group Home

☐ Senior Apartment ☐ Skilled Nursing Facility

3. Is the applicant currently enrolled in a Wisconsin Department of Health Services long-term care program? *(mark all that apply)*

☐ My Choice Family Care ☐ Community Care ☐ IRIS ☐ PACE ☐ iLife

☐ iCare ☐ Other _____ ☐ Not currently enrolled in a long-term care program

Contact information for long-term care program case manager, representative, or consultant:

Name: _____

Phone: _____ E-Mail: _____

Part 3: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Applicant Name: _____ D.O.B.: _____

I certify that, to the best of my knowledge, the information given on this application is true and accurate. I understand that MCTS will rely upon this information when determining my eligibility for participation in the Transit Plus program. I also understand that providing false or misleading information could result in my eligibility status being revoked or denied.

I authorize the provider(s) named here, his/her officers, employees, agents, contractors, members, directors, shareholders or affiliates entrusted with handling medical records, to disclose to MCTS/Transit Plus all of the protected health information relating to me that is ***reasonably necessary*** *for the provider to fully and accurately complete Part 4 of this application.*

1. Name of Provider: _____

Office or Facility Address: _____

Office Phone: _____

2. Name of Provider: _____

Office or Facility Address: _____

Office Phone: _____

3. Name of Provider: _____

Office or Facility Address: _____

Office Phone: _____

This authorization shall remain in effect until my eligibility for Transit Plus paratransit services is finally determined or 90 days from the date of the authorization, whichever occurs first. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the persons named above. I understand that the revocation of this authorization is not effective to the extent that the named provider has relied upon it for the use or disclosure of the protected health information prior to receiving my written revocation notice.

I understand that any protected health information disclosed pursuant to this Authorization to an individual or entity that is not covered by state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I acknowledge that the named persons will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I sign this Authorization.

_____

Applicant Printed Name | Signature | Date

The following Representative signed on my behalf:

☐ Parent (if applicant is a minor) ☐ Power of Attorney ☐ Legal Guardian

☐ As the Applicant, I signed on my own behalf

Part 4: HEALTH CARE PROVIDER VERIFICATION

Federal law requires that Transit Plus provide comparable paratransit services to persons who cannot use available Fixed Route bus service. The information provided will allow Transit Plus to make an appropriate evaluation of this applicant's functional abilities. Please fill in all sections that pertain to the applicant's disabilities as they relate to using public transportation.

Your patient's application for Transit Plus eligibility will be reviewed to determine whether they qualify for Paratransit services under the Americans with Disabilities Act (ADA). A person's eligibility for Paratransit services is dependent upon:

1) *Inability to navigate the system independently;*
2) *Lack of accessible vehicles, stations, or bus stops* ***(All MCTS buses are accessible)****; or*
3) *Inability to reach a boarding point or final destination.*

Application for Paratransit Eligibility Certification

Unreadable or incomplete applications will be returned.

Professional's Name (Printed): _____

Professional's Title/Position: _____

Professional License # (Required): _____

Office Address: _____

Office Phone: _____ E-mail: _____

Patient's Name: _____ D.O.B _____

1. What is the nature of the disability/condition? (Check all that apply)

☐ Intellectual ☐ Sensory ☐ Physical

2. If the applicant has a visual impairment; the following are required:

Visual Acuity (with best correction): Left Eye: _____ Right Eye: _____

Visual Fields: Left Eye: _____ Right Eye: _____

Light Perception: Left Eye: _____ Right Eye: _____

3. What is/are the applicant's disabilities/diagnosis?

_____

_____

4. If multiple conditions/disabilities are listed; identify the ***most limiting condition*** affecting patient's ability to utilize public transportation on the fixed route bus.

_____

5. When did you last see the applicant for the previously stated condition(s)?

Date: _____

6. Is this condition: ☐ Temporary ☐ Permanent ☐ Progressive

7. What is the current severity of the above disability? ☐ Mild ☐ Moderate ☐ Severe

8. In your professional opinion is this applicant prevented from utilizing public transit due to their disability/condition? ☐ Yes ☐ Sometimes ☐ No

If "yes" or "sometimes", please explain: _____

_____

Application for Paratransit Eligibility Certification

9. How is the applicant being treated for listed disability/condition?

Medication: _____

Mobility Device: _____

Therapy: _____

Programs: _____

Surgical Procedure: _____

Other: _____

10. How is the applicant managing/ responding to treatment?

☐ Worsening Condition ☐ Stable ☐ Somewhat Effective ☐ Very Effective

11. Is the applicant prevented by disability from completing daily activities?

☐ Yes ☐ Sometimes ☐ No

I certify that the information contained in this application is true and correct to the best of my knowledge and ability. I hereby verify that the diagnosis of disability listed has been reviewed by me, is accurate and true and represents the current physical and/or mental condition of the applicant named below.

Patient's Name: _____ D.O.B: _____

Professional's Signature: _____ Date: _____

(Please note that this application is only valid for up to 90 days from date of signature)

Once complete, your application can be submitted in one of the following ways:

U.S. Postal Service:
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Milwaukee, WI 53205

E-mail:
TPlusApplications@mcts.org

In-Person:
8:30am – 4:00pm
at the Transit Plus Office
1942 N 17th Street
Milwaukee, WI 53205

Please be advised that The Transit Plus Office will NOT accept Faxes.