TRANSITPLUS
PARATRANSIT SERVICE

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. If you skip any part of the application, we cannot determine your eligibility. Incomplete forms will be returned to sender unprocessed. 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.

Important notes on the Medical Verification Form:

- **The medical verification form must be filled out by a licensed healthcare provider.** The form is valid for 90 days from the date of the provider's signature.
- If you or non-licensed healthcare provider fill out the medical verification form, your application will be invalid.
- Additional medical documentation is allowed, but will not be accepted as a substitute for the medical verification form.

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

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 and medical verification form, you will be contacted to schedule your in-person assessment appointment.

Any applicant who requires personal care/toileting assistance or behavioral supervision- must be accompanied by a caregiver or family member.

1. **Complete the Eligibility Application**

   ☐ I filled out the application completely.

   ☐ I provided my current contact information, including a valid email address, if applicable.

   ☐ I signed the form.

   ☐ I understand the applications are processed in the order received, and that all parts of the application must be **complete** or it will be returned to me.

2. **Make a copy for your records**

   ☐ I made a copy of my completed application for my personal records. Transit Plus does not provide copies.

3. **Submission of application**

   ☐ I submitted my application in one of the following ways:

      ☐ Mailed to: 1942 N. 17th St. Milwaukee, WI 53205.

      ☐ In-person between 8:30 am and 4:00 pm.

4. **Ask your authorized licensed healthcare provider to complete the Medical Verification Form**

   ☐ I contacted my medical provider and directed them to complete the medical verification form. Your medical provider can fill out this form online or can print the form to be filled out manually.

   ☐ My provider completed the medical verification form online or if completed by paper, they returned it to me or sent it directly to the Transit Plus Office.

5. **Assessment appointment scheduling**

   ☐ I understand that after my completed application and medical verification have been reviewed by Transit Plus staff, I will be contacted to schedule an in-person assessment appointment at the Transit Plus Office.

TRANSITPLUS
PARATRANSIT SERVICE

1942 North 17th Street
Milwaukee, Wisconsin 53205-1697

Phone: (414) 343-1700
TTD: (414) 343-1704

Application for Transit Plus Service

Client Information

All fields marked with * are required and must be filled.

Client Last Name *

Client First Name *

Client Middle Name

Age *

Date of Birth *

Gender *

SSN *

I do not have an SSN

Are you already a Transit Plus Client?

Mobile Phone

Please enter a valid phone number.

Home Phone

Please enter a valid phone number.

Email

example@example.com

Address: *

Apt/Unit:

City: *

State: *

Zip: *

Should the Transit Plus Office use this mailing address for all future correspondence? *

Yes

No

Emergency Contact Information

Emergency Contact Name (Last, First, M.I.) *

Relationship to Client *

Address:

Apt/Unit:

City:

State:

Zip:

Phone Number *

Please enter a valid phone number.

Email

example@example.com

Which of the following best describes the current living arrangement of the applicant? *

- ◯ Private Home/ Apartment
- ◯ Assisted Living Facility
- ◯ Senior Apartment
- ◯ Group Home
- ◯ Rehab/Skilled Nursing Facility

Long-term Care Program Affiliation

Is the applicant currently enrolled in a Wisconsin Department of Health Services care Program? (Mark all that apply) *

- ☐ My Choice Family Care-Care Wisconsin
- ☐ Community Care
- ☐ iCare
- ☐ PACE (Program of All-inclusive Care for the Elderly)
- ☐ IRIS: (Premier, iLife, Outreach Health, GT Independence, Adovocates4U, Connections, First Person Care Consultants, TMG)
- ☐ Title 19/ Medicaid
- ☐ Not currently enrolled in a care program.
- ☐ Other

Please include the following contact information for any affiliated care program case manager, representative or consultant:

Case Manager/Consultant Name (Last, First, M.I.)

Phone Number

Please enter a valid phone number.

Email

example@example.com

Assistive Devices Inventory

Please mark all the assistive devices that the applicant uses all or some of the time: *

- ☐ White Cane
- ☐ Crutches
- ☐ Prosthesis
- ☐ Service Animal
- ☐ Motorized Wheelchair
- ☐ Motorized Scooter
- ☐ Other
- ☐ Walking Cane
- ☐ Walker/Rollator
- ☐ Portable Oxygen
- ☐ Manual Wheelchair
- ☐ Extra Wide Wheelchair (> 30 "wide)
- ☐ None

*** Please note, individuals using mobility devices that exceed 30” in width and/or 48” in length (measured 2” above the ground) or applicants and their mobility devices having a combined weight of more than 600lbs when occupied, may not be able to be accommodated on Transit Plus vehicles.**

Authorization to Disclose Protected Health Information

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 the Healthcare Provider Verification portion of this application.

Name of Health Care Provider *

Office or Facility Address

Provider Office Phone *

Please enter a valid phone number.

Email

example@example.com

Authorization Statement

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's Name *

Date *

Applicant Signature *

The following Representative signed on my behalf: *

- [ ] As the Applicant, I signed on my own behalf
- [ ] Power of Attorney
- [ ] Legal Guardian
- [ ] Parent (if applicant is a minor)