TOWNSHIP RIDERS INITIATIVE PROGRAM (TRIP)

BUS RIDERSHIP REGISTRATION FOR DISABLED ADULTS OVER 18 YEARS OF AGE

PALATINE TOWNSHIP

PHONE: 847-358-6907 FAX: 847-358-2888

CONTACT NAME: JERALD WOLFF; PALATINE TOWNSHIP FUNDING SOURCE CODE: PAL TWN

NAME: _____**BIRTH DATE:** _____ **GENDER:** _____

ADRESS: _____ **CITY:** _____

Nearest Major Cross Streets: _____

TOWNSHIP: _____ **ZIP CODE:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

PHONE 1: _____ __**PHONE 2:** _____

REGISTERED WITH PACE ADA: YES ☐ **NO** ☐

PLEASE DESCRIBE YOUR DISABILITY: _____

BELOW, PLEASE CHECK ALL CATEGORIES THAT APPLY:

MOBILITY LIMITED: _____ **HEARING IMPAIRED:** _____ **RESPIRATORY:** _____

VISUALLY IMPAIRED: _____ **SPEECH IMPAIRED:** _____ **NEUROLOGICAL:** _____

AIDS USED; PLEASE CHECK ALL THAT APPLY:

WHEELCHAIR: _____ **WALKER:** _____ **BRACES:** _____ **PROSTHETIC DEVICE:** _____

ATTENDANT: _____ **CRUTCHES/CANE:** _____ **SERVICE ANIMAL:** _____ **OTHER:** _____

DO YOU OWN A TTY (telecommunications for the Deaf)? YES _____ **NO** _____ **if Yes, #:** _____

Do you need the LIFT equipped bus: YES____ **NO**____ **/ What is your primary language spoken:** _____

APPLICANT'S SIGNATURE: _____ DATE: _____

Definition: "Handicapped Person" Chapter 95 ½ , Par. 1-159.1, Illinois Revised Statutes (PA83-1058) "Every natural person who is unable to walk 200 feet or more unassisted by another person or without the aid of a walker, crutches, braces, prosthetic device, or a wheelchair or without great difficulty or discomfort due to the following impairments: neurological, orthopedic, respiratory, cardiac, arthritic disorder, blindness, or the loss of function or absence of a limb or limbs."

I hereby certify that the physical condition of the handicapped person listed herewith constitutes him/her as a handicapped person as described under section 1-159 of the Illinois Revised Statutes, and is over the age of 18.

Physician's Signature: _____ **Physician's License Number:** _____

PHYSICIAN'S NAME: _____

ADDRESS: _____**PHONE:** _____

CITY: _____ **ZIP CODE:** _____

FOR OFFICE USE ONLY

PROOF OF RESIDENCY USED: _____

APPROVED: _____ **DENIED:** _____ **REASON FOR DENIAL:** _____

APPROVED BY: _____ **DATE OF APPROVAL:** _____