Dear Applicant,

All riders with disabilities must file an application with a Physician's Certification that they are eligible for Specialized Transportation. Eligibility criteria will be determined by the Racine County Human Services Department. Racine County and/or Ktown Transportation will process applications for eligibility and notify the applicant within 21 days of their approval or denial of the application.

Attached is the application for Racine County Specialized Transportation. Please read the eligibility information carefully.

Please fill out the Applicant Information Form and the Release of Information Form completely. A legal guardian must sign the Release of Information if the individual has one so appointed by a court of law, or is under 18 years of age.

Have your primary physician fill out the Physicians Certificate of Disability. Your doctor must personally sign the certificate.

When completed, send the Applicant Information Form, Release of Information Form and Physician's Certification of Disability form to:

Ktown Transportation
Attn: Lynda Orsburn
6946 46th Street
Kenosha, WI 53144

If you have any questions about the form, please contact us at 262-764-0377 and ask for Tammy or Lynda.

Racine County Specialized Transportation Service
Applicant Information

Title: ___Mr. ___Ms. ___Miss ___Mrs. ___ Social Security Number: _____

Last Name: _____ First Name: _____

Address: _____ Apartment #_____

City: _____ State:_____ Zip Code:_____

Home Telephone Number: _____Work: _____Cell:_____

Date of Birth:_____ Sex: _____Male _____Female

Do you receive Title 19 (Medicaid) assistance? Yes ____ No ____

Primary Language: _____English _____Sign _____Other:_____

Are you able to walk without assistance? Yes____ No____

If no, what type of mobility device do you use? _____

Mailing Address, if different from above, where any written information or notification concerning Specialized Transportation Service should be sent:

Address: _____ Apartment #_____

City: _____ State:_____ Zip Code:_____

Emergency Contact Information

Last Name: _____ First Name: _____

Address: _____ Apartment #_____

City:_____ State:_____ Zip Code:_____

Home Telephone Number: _____Work: _____Cell:_____

Relationship: _____

Racine County Specialized Transportation Service
Applicant Information

AUTHORIZATION OF RELEASE OF INFORMATION

I, the applicant, authorize the release of information requested to the Agency and any eligibility review panel, and understand that the requested information will be treated as confidential and be used solely for the purpose of determining my eligibility to utilize the Specialized Transportation Services of Racine County. I understand that the Agency reserves the right to request additional information at its discretion for the purposes of determining my eligibility.

Signature of Applicant: _____ Date: _____

Printed Name of Applicant: _____

Signature of Preparer (*if other than applicant*): _____ Date:_____

Printed Name of Preparer: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____

Please send or deliver the completed form to:

Ktown Transportation
Attn: Lynda Orsburn
6946 46th Street
Kenosha, WI 53144

Racine County Specialized Transportation Service
Physicians Certificate of Disability

The applicant named on the attached "Release of Information" form is applying for Racine County's Specialized Transportation Program. The Paratransit program allows applicants with serious health conditions and / or disabilities to utilize door-to-door transportation within Racine County when no other means of transport is available. Racine County Specialized Transportation does not serve residents within ¾ of a mile of existing City (Belle Urban) bus routes. Please contact the City for options in this area.

In the space provided below, please describe the health, psychological or developmental condition(s) that quality this applicant for transportation.

_____

_____

_____

_____

_____

_____

Does the applicant require the use of a mobility aid? Yes ____ No ____

If yes, what type of mobility aid does the applicant use? _____

Will the applicant be using oxygen when traveling? Yes ____ No ____

Will the applicant be using any other breathing device or mobility aids or equipment?

(Please Specify)

_____

Does the applicant require the assistance of a Personal Care Attendant (PCA) during transport?

Yes ____ No ____

Is the applicant a certified Title 19 Medicaid patient? Yes ____ No ____

I certify that (applicant's name) _____ is eligible ____, is not eligible ____ for Racine County Specialized Transportation Services.

Physician Name: _____

Office Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ NPI # _____ UPIN #_____

Physicians Signature: _____ Date: _____