



TOWNSHIP RIDERS INITIATIVE PROGRAM (TRIP) CLIENT ID # _____

PALATINE TOWNSHIP BUS SERVICE CLIENT ID # _____

BUS RIDERSHIP REGISTRATION FOR SENIOR CITIZENS AGE 60 & OVER

BUS RIDERSHIP REGISTRATION FOR DISABLED CITIZENS AGE 18 TO 59

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: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

Nearest Major Cross Streets: _____ TOWNSHIP: PALATINE

HOME PHONE: _____ CELL PHONE: _____

1ST EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE 1: _____ PHONE 2: _____

2ND EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE 1: _____ PHONE 2: _____

REGISTERED WITH PACE ADA: YES ___ NO ___

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: _____ OXYGEN: _____

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

IF DISABLED, PLEASE DESCRIBE YOUR DISABILITY:

Do you need the LIFT equipped bus: YES ___ NO ___ What is your primary language spoken: _____

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

APPLICANT'S SIGNATURE: _____ DATE: _____

Taxi Voucher Card: YES ___ NO ___ Use of Photo Authorization Signature for Voucher Card: _____

THIS PORTION FOR DISABLED CITIZENS AGE 18 TO 59 ONLY

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: _____