

TOWNSHIP RIDERS INITIATIVE PROGRAM (TRIP)
BUS RIDERSHIP REGISTRATION for DISABLED ADULTS OVER 18 YEARS OF AGE

HANOVER TOWNSHIP AGING SERVICES
PHONE: 630/ 483-5656 OR 630/ 483-5668 FAX: 630-463-5690
Hanover Township Aging Services Funding Source Code: **Hanover**

(Please print in Black Ink)

Name _____ Birth Date _____
Address _____ Phone _____
Cell Phone _____
City _____ Zip Code _____
Township _____ Gender _____
Emergency Contact _____ Phone _____
Other Phone _____ Relationship _____

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Please Describe Your Disability: _____

_____ Please Check All Categories That Apply:

_____ Mobility Limited _____ Hearing Impaired _____ Cardiac
_____ Visually Impaired _____ Respiratory _____ Neurologic
_____ Speech Impaired _____ Renal/ On Dialysis _____ Cancer

Aids Used (if any): _____ Wheelchair _____ Walker X Escort _____ Braces
 _____ Prosthetic Device _____ Crutches or Cane _____ Service Animal

Do You Own a TTY (Telecommunications for the Deaf?) _____ YES _____ NO

 If Yes, What is the TTY Number? _____

Do You Need the Lift Equipped Bus? _____ Yes _____ No

What is Your Primary Language Spoken? _____

Applicant's Signature _____ DATE _____

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Definition: Handicapped Person" Chapter 95 1/2 , 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 (Please Print) _____

Address _____ Phone _____

City _____ Zip Code _____

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For office use only
Proof of Residency Used _____
Approved _____ Denied _____ Reason for Denial _____
Approved By _____
Date of Approval _____

