Application for the Rural Program
(Over 60 & Under 60)

The attached application must be completed to apply for the Under 60 and Over 60 rural transportation programs. See chart below for brief descriptions of each program. These programs are designed to provide transportation assistance to rural county residents that are elderly or disabled.

Program (Card color)	Eligible User	Service Area
Under 60 (Red)*	Rural county resident that is disabled	Winnebago County
Over 60 (Blue)*	Rural county resident over 60 years	Winnebago County

*not available to the residents of Menasha, Neenah, and Oshkosh (where other comparable paratransit programs exist).

The Red Cross processes the applications for the programs above on the behalf of the Oshkosh Transit System (OTS). OTS and Red Cross consider all information provided strictly confidential and will not share your answers with any other person or company unless authorized or legally required. If necessary, an appointment with Occupational Health may be scheduled by the City to determine if your disability qualifies you for transportation assistance.

Under 60 rural program applicants must re-apply each year. Over 60 applicants only need to apply once.

Please return completed form to:

American Red Cross
515 S. Washburn, Ste 201
Oshkosh, WI 54904

Applicants need to complete all applicable parts of the form. Incomplete applications will not be processed and will be returned to the applicant. If you have any questions, please call the American Red Cross at 231-3590.

Successful applicants will be mailed a card with written instructions on how to use the program.

For more information on OTS's elderly and disabled transportation programs, please call 232-5341.

A. IDENTIFICATION INFORMATION

PLEASE PRINT

Name: ____

Address: ____

City, State, Zip Code: ________________________________

New Address (if different): ________________________________

City, State, Zip Code: ____________________________________

Date of Birth (m/d/y): ________________________________

Home phone number: _____________________

Gender: ☐ Male ☐ Female

B. MOBILITY INFORMATION

Note: *If you are applying for the Over 60 rural program (applicant is 60 years of age or older), skip the questions in sections B & C and simply complete the last two lines of this application on the bottom of page 4 (signature, date, and daytime phone number).
***Under 60 rural program applicants should complete all parts of this form.**

1. Which of these mobility aids or equipment do you need to help you get to where you need to go? [Please check all that apply to you]

   ☐ None ☐ Manual wheelchair ☐ Service dog
   ☐ White Cane ☐ Power wheelchair ☐ Portable oxygen
   ☐ Walker ☐ Powered scooter/cart
   ☐ Other ____________________________

C. DISABILITY OR HEALTH CONDITION INFORMATION

1. Check any general medical conditions that you have: ☐ None

☐ Alzheimer's Disease
☐ Brain Injury
☐ Cerebral Palsy
☐ Congestive Heart Failure
☐ Cystic Fibrosis
☐ Deaf-Blind
☐ Dementia
☐ Other ___________________
☐ Epilepsy
☐ Guillian-Barre
☐ Hemiplegia
☐ Huntington's Chorea
☐ Kidney Failure
☐ Legally Blind
☐ Lung Cancer
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Paraplegia
☐ Parkinson's Disease
☐ Quadriplegia
☐ Spina Bifida
☐ Stroke

2. Is your health condition or disability temporary?

☐ Yes → How long do you expect it to last? __________________

☐ No → How long have you had this condition or disability?
☐ Since birth or ☐ # of years

☐ I don't know → Please describe: _______________________________________

3. Does your disability or health condition change from time to time in ways that affect your ability to travel?

☐ Yes → Please describe: _______________________________________

☐ No

4. In order for your request to be evaluated, it may be necessary to contact a physician or other professional to confirm the information that you have provided. Please complete the following information and authorization form.

   The following (check one) is familiar with my disability and is authorized to provide Occupational Health Systems with the information required to complete this certification.

   ☐ Physician ☐ Health care professional ☐ Rehabilitation professional

   **Must be current physician or professional info.*

   Professional's name ____

   Address ____

   City ___________________________State ___________ Zip___________

   Telephone number ____

I solemnly affirm that the information I have provided on this application is complete and true to the best of my knowledge and belief and that intentional deception herein may be considered as significant cause for the disqualification from OTS Paratransit Programs. I will not loan my card to anyone. I also understand that my I.D. card may be confiscated by OTS if it is used improperly. I understand further that the OTS reserves the right to request additional information at its discretion.

Signature of applicant or guardian (if appropriate): __________________________

Date: ___________ Daytime phone # (if proxy): ______________________