



## **Elk Grove Township Taxi Service**

Who is eligible? Disable residents over the age of 18 and senior citizens over age 55.

Individuals that are disabled are defined as the following:

- Developmentally disabled
- ADA certified
- Marked or extreme mental illness

Individuals age 55 years and above do not have to have prior approval of their physicians to use this service.

All registered and approved riders will be issued a debit card. Each swipe is worth \$5.00 and can be used once for a one-way trip. Taxi rides will be through the 303 Taxi in Mount Prospect.

### **Applicants must supply the following for approval:**

- Proof of residency, such as a current gas, electric bill, or state ID.
- Proof of age, please include a copy of your ID with application.
- Proof of disability, please have your physician complete the Physician's Authorization form.

For questions and/or help with this application call 847-437-0300.

### **Return complete application to:**

Elk Grove Township  
600 Landmeier Road  
Elk Grove Village, IL 60007



Elk Grove Township  
600 Landmeier Road  
Elk Grove Village, IL 60007  
847-437-0300  
Fax 847-437-0434

**Elk Grove Township Taxi Service Application**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Office Use Only**

Proof of Residency Provided Form of Proof: \_\_\_\_\_

**Application**

Approved Rider Number \_\_\_\_\_

Denied Reason Denied \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_



**Physician's Authorization**

I hereby certify that the condition of the person with disabilities listed herewith constitutes him/her as a person with disabilities as described below:

1. Developmentally disabled
2. ADA Certified (Please note that the person with a physical disability are described under 625 ILCS 5/1-159.1)\*
3. Marked or extreme mental illness

Please fill in the name of the person with the disability and state the disability.

Name of Person with Disability: \_\_\_\_\_

Disability: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's License Number

**Please Print or type below:**

Physician's  
Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\*Definition of "Persons with Disabilities" (625ILCS 5/1-159.1)

"A natural person who as determined by a licensed physician: (1) cannot walk without a use of or assistance from, a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; (2) is restricted by lung disease to such an extent that his or her forced(respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or that arterial oxygen tension is less than 60mm/hg on room air rest; (3) uses portable oxygen; (4) has a cardiac condition to the extent that the person's functional limitations are classified in severity as Class III or Class IV according to the standards set by the American Heart Association; or (5) is severely limited in the person's ability to walk due to arthritic, neurological or orthopedic condition; (6) cannot walk 200 feet without stopping to rest because of one of the above conditions."