



**Eligibility and Registration Form
Rural Transportation for Persons with Disabilities (PwD) Project
and ADA Complementary Paratransit Service (ADA)**

- PWD Reduced fare transportation service may be available to you if you are:
 - 1) A person with a disability and
 - 2) Under 65 years old and
 - 3) Live in a county participating in the project and
 - 4) Need transportation to or from an area that is not currently served by public fixed route bus transportation and ADA complementary Para transit services.

- ADA service may be available to you if you:
 - 1) A person with a disability and
 - 2) You need transportation that could normally be made on a FACT fixed-route bus

➤ If you would like to participate in these projects, please complete this form and send it with a copy of one of the documents listed in Part 2 below to:

*Fayette Area Coordinated Transportation
825 Airport Road
Lemont Furnace, PA 15456*

➤ Once your application is received and reviewed you will be notified in writing within 30 days upon receipt of your application.

➤ If you have questions about this project, this form or need this form in an alternate format please call:
800-321-RIDE (7433)

Note: The information provided in this application regarding your disability will be used to determine your eligibility for reduced fare transportation services under the PwD and ADA projects. Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and to provide you with the appropriate type of service. This information will be kept confidential and used only by professionals involved in evaluating your eligibility and in analyzing the pilot project for future recommendations. Please print clearly.

PART 1: GENERAL

Last Name: _____ First Name: _____ M.I.: _____
 Address (Street & No.): _____
 City: _____ State: _____ Zip Code: _____
 Telephone: Home: _____ Work: _____ E-mail: _____
 County of Residence: _____ Date of Birth: _____
 Social Security Number _____

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?
 Yes No

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disability Act (ADA). According to the ADA, "Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". "...a major life activity means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

PART 2: WRITTEN VERIFICATION THAT YOU ARE A PERSON WITH A DISABILITY

Written verification by a knowledgeable organization or qualified individual that you are a person with a disability is required to participate.

1. If you have written verification of a disability:

You may already have written verification that you are a person with a disability from a service organization by having an identification card, a written assessment of your disability, etc. If so, send a copy of this information to the transportation provider listed at the top of this form. If not, you will need to ask an organization or individual listed below to verify, in writing, that you are a person with a disability according to the ADA definition and then send it to the transportation provider listed at the top of page 1.

Please check the organization or individual whose written verification you are submitting with your application form.

- | | |
|--|--|
| <input type="checkbox"/> Office of Vocational Rehabilitation (OVR) | <input type="checkbox"/> Registered Physical/Occupational Therapist |
| <input type="checkbox"/> Social Security Insurance (SSI) and Disability Insurance (SSDI) | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Bureau of Blindness and Visual Services | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Center for Independent Living (CIL) | <input type="checkbox"/> PA Attendant Care Program |
| <input type="checkbox"/> Mental Health/Mental Retardation Program | <input type="checkbox"/> Community Services Program for Persons with Physical Disabilities |
| <input type="checkbox"/> United Cerebral Palsy | <input type="checkbox"/> Other: _____ |

2. If you do not have written verification of a disability:

Please fill out a certification of disability form available from our office. It provides verification of a disability according to the definition in the Americans with Disabilities Act. This form can be used to acquire the necessary information for verifying a disability from a qualified health professional. See Exhibit F in this package.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

Passenger income related data is being collected for further decision-making regarding the project. THIS INFORMATION WILL NOT BE USED TO DETERMINE ELIGIBILITY FOR DISCOUNTED FARES UNDER THE PwD PROGRAM. Please check the appropriate space in each column:

Annual Income	Household Size
<input type="checkbox"/> Less than \$10,000	<input type="checkbox"/> 1
<input type="checkbox"/> \$10,001-\$15,000	<input type="checkbox"/> 2
<input type="checkbox"/> \$15,001-\$20,000	<input type="checkbox"/> 3
<input type="checkbox"/> \$20,001-\$25,000	<input type="checkbox"/> 4
<input type="checkbox"/> \$25,001-\$30,000	<input type="checkbox"/> 5
<input type="checkbox"/> \$30,000-\$35,000	<input type="checkbox"/> 6
<input type="checkbox"/> \$35,001-\$40,000	<input type="checkbox"/> 7
<input type="checkbox"/> \$40,001-\$45,000	<input type="checkbox"/> 8+

PART 4: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the PwD and ADA projects are not to be provided in place of any current transportation services that you already receive.

1. Do you now receive any transportation services or are any of your transportation costs paid for by another program or organization? Please complete all that apply from the following list.

- Senior Citizens Shared-Ride Transportation Program
- Area Agency on the Aging
- Medical Assistance Transportation Program
- Americans with Disabilities Act Complementary Paratransit
- Mental Health/Mental Retardation (MH/MR)
- Office of Vocational Rehabilitation (OVR)
- The training program I am in at _____
- The employment program I am in at _____
- The group home where I live.
- Other (please explain) _____

2. If you are not registered for the Medical Assistance Transportation Program (MATP), you may qualify. MATP could pay all of the cost for your eligible medical trips. If appropriate, you will be referred to the County Assistance Office (CAO).

- I have been informed of *pending referral* to the County Assistance Office (CAO)
- I was referred to the CAO for MATP eligibility determination on (date): _____
- Initials of staff person making the referral to the CAO _____

PART 5: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent? Yes No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.)
2. If not, how long is it expected to last? _____
3. What is the nature of your disability? Check those that apply.
 - Mobility disability (please see question 4 below)
 - Vision disability
 - Hearing disability
 - Cognitive disability
 - Mental disability
 - Other - Please specify _____
4. Please check all mobility aids that apply.

<input type="checkbox"/> Manual wheelchair	<input type="checkbox"/> Crutches
<input type="checkbox"/> Power Wheelchair	<input type="checkbox"/> Cane
<input type="checkbox"/> Motorized Scooter	<input type="checkbox"/> Walker

5. Do you require the services of a personal care attendant or escort when you travel? (A personal care attendant or escort is a person that you need to assist you during the trip or at your origin or destination)

_____ Yes

_____ No

_____ Sometimes

Please describe when you need assistance: _____

6. Emergency Contact (Optional)

Name: _____

Relationship: _____

Phone (Home): _____ (Work): _____

7. Is there anything else you want us to know so we can serve you better? _____ Yes _____ No

If "Yes," please describe _____

PART 6: RELEASE OF INFORMATION and YOUR CERTIFICATION OF THE APPLICATION FORM

Release of Information

I give my permission to _____ to contact a health care or other professional that I designate additional information to verify that I am a person with a disability.

Yes _____ No _____

Your Signature or That of the Person Who Completed This Form

Date

I understand that the purpose of this application is to determine if I am eligible to participate in the PwD project. I certify that the information contained in this application is correct and truthful to the best of my knowledge.

Your signature or that of the person who completed this form

Date

Name of the person who completed this form

Relationship

Telephone number

**Certification of Disability Form
Reduced Fare Transportation Services
Rural Transportation for Persons with Disabilities (PwD) Program/ADA Complementary Paratransit Service**

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. This form is to be completed by a profession who is familiar with the applicant's disability. A professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services to people with disabilities. The applicant has applied for transportation services under the ADA Complementary Paratransit Service and Rural Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by the Fayette Area Coordinated Transportation office. If you have any questions about the form, please call 1-800-321-7433.

Applicant Information (to be completed by applicant):

Last Name: _____ First Name: _____ M.I.: _____

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ E-mail: _____

Applicant signature or that of the person who completed this form Date

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disability Act (ADA). According to the ADA, "Disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment". "...a major life activity means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

Please answer the following questions **(to be completed by the agency or person providing verification of eligibility information)**

Is the applicant's disability permanent? Yes No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.)

If not, how long is it expected to last? _____

What is the nature of the applicant's disability? Check those that apply.

- Mobility disability (please see question to the right)
- Vision disability
- Hearing disability
- Cognitive disability
- Mental disability
- Other - Please specify _____

- Please check all mobility aids that apply.
- Manual wheelchair Crutches
 - Power Wheelchair Cane
 - Motorized Scooter Walker

Signature of Professional Date

Title Name of Agency or Organization

Address Telephone

Please send completed form to: **Fayette Area Coordinated Transportation, 825 Airport Road, Lemont Furnace, PA 15456**