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.

_____Office of Vocational Rehabilitation (OVR)

_____Social Security Insurance (SSI) and Disability Insurance (SSDI)

_____Bureau of Blindness and Visual Services

_____Center for Independent Living (CIL)

_____Mental Health/Mental Retardation Program

_____United Cerebral Palsy

_____Registered Physical/Occupational Therapist

_____Physician

_____Registered Nurse

_____PA Attendant Care Program

_____Community Services Program for Persons with Physical Disabilities

_____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

_____Less than $10,000
_____$10,001-$15,000
_____$15,001-$20,000
_____$20,001-$25,000
_____$25,001-$30,000
_____$30,000-$35,000
_____$35,001-$40,000
_____$40,001-$45,000

Household Size

_____1
_____2
_____3
_____4
_____5
_____6
_____7
_____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.

_____Manual wheelchair _____Crutches
_____Power Wheelchair _____Cane
_____Motorized Scooter _____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 FACT 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

Attachment F

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***