



## Rural Transportation for Persons with Disabilities (PwD) Project Eligibility and Registration Form – Instructions For Applicant Union/Snyder Transportation Alliance

The standard eligibility and registration form is a total of four pages. This form is also available in large print, and other formats (Braille and on tape). If you require an alternate format, contact Union/Snyder Transportation Alliance (USTA). The following instructions summarize the major sections of the form and provide assistance in effectively completing the form and providing the required documentation to USTA.

### Part 1: General

- Please print your name, address and other identifying information on the form;
- Respond to the question of whether or not you have a disability based on the ADA definition by checking Yes or No;
- Please clearly print directions to your home/description of your home.
- The ADA definition of a disability is quoted.

### Part 2: Written Verification That You Are A Person With A Disability

- You must provide written verification of a disability to be eligible for discounted shared-ride fares through the PwD project;
- If you have worked with one of the agencies listed on Page 2 of the application, submit a copy of a document from them that describes and certifies your disability.
- If you do not have some form of written verification, please contact one of the organizations, or similar, listed on page 2 for confirmation of a disability or use Attachment E, the PwD project's certification of disability form and return the form to USTA;
- Please identify the organization providing the written verification.

### Part 3: Income and Household Related Data

- Please place a check next to a range that matches your gross annual income. It is the same as that reported for tax purposes;
- Please place a check next to the appropriate number for household size. Household size means the number of persons who reside in your private residence.

Note: This information is required for statistical purposes, but does not affect eligibility for PwD.

### Part 4: Avoiding Duplication of Transportation Services

- The PwD project is not to replace current transportation services;
- If current transportation services and costs are covered by another program, you must identify all of the funding sources from the list provided;
- If you are a current MATP client, you must provide your Access Card issue and Recipient numbers.

**Note: Do not complete section number 2**

- USTA staff will check that, if applicable, they have informed you of your referral to the County Assistance Office (CAO) for a determination of eligibility for Medical Assistance (MA) and other programs;



2/09

**Eligibility and Registration Form  
Rural Transportation for Persons with Disabilities (PwD) Project  
Union/Snyder Transportation Alliance**

- ◆ Reduced fare transportation service may be available to you if you are:
  1. A person with a disability and
  2. Between the ages of 18 and 64
  3. Need accessible public transit in a participating county beyond ADA complementary paratransit services.
- ◆ If you would like to participate in this project, please complete this form and send it with a copy of one of the documents listed in Part 2 below to:

*Union/Snyder Transportation Alliance  
1610 Industrial Blvd., Suite 700  
Lewisburg, PA 17837*

- ◆ Once your application is received and reviewed you will be notified of your eligibility to participate.
- ◆ If you have questions about this project, this form or need this form in an alternate format please call:  
1 (877) 877-9021

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 project. 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: \_\_\_\_\_ Township of Residence: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ (optional)

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". "...major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

Directions to your home (description of your house): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 in the PwD project.

**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 Union/Snyder Transportation Alliance at the address noted above. 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 Union/Snyder Transportation Alliance (USTA). 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 Attachment 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:

<b>Annual Income</b>	<b>Household Size</b>
<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 +
<input type="checkbox"/> \$45,001-\$50,000	
<input type="checkbox"/> \$50,001-\$55,000	
<input type="checkbox"/> \$55,001-\$60,000	
<input type="checkbox"/> \$60,001+	

**PART 4: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES**

Transportation services provided under the PwD project 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--Recipient # \_\_\_\_\_ Card Issue # \_\_\_\_\_
- 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 faxing 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 USTA to contact a health care or other professional that I designate for additional information to verify that I am a person with a disability.

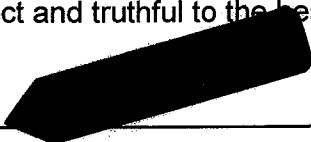
Yes  No



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 C**

**Certification of Disability Form  
Reduced Fare Transportation Services  
Rural Transportation for Persons with Disabilities (PwD) Program  
Union/Snyder Transportation Alliance**

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 Rural Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by the Union/Snyder Transportation Alliance. If you have any questions about the form, please call 1-877-877-9021.

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". "...major life activities 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.    Please check all mobility aids that apply.

- |                                                                                 |                                            |                                   |
|---------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Mobility disability (please see question to the right) | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Vision disability                                      | <input type="checkbox"/> Power Wheelchair  | <input type="checkbox"/> Cane     |
| <input type="checkbox"/> Hearing disability                                     | <input type="checkbox"/> Motorized Scooter | <input type="checkbox"/> Walker   |
| <input type="checkbox"/> Cognitive disability                                   |                                            |                                   |
| <input type="checkbox"/> Mental disability                                      |                                            |                                   |
| <input type="checkbox"/> Other — Please specify: _____                          |                                            |                                   |

\_\_\_\_\_  
Signature of Professional

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Name of Agency or Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

Please send completed form to: **Union./Snyder Transportation Alliance, 1610 Industrial Blvd., Suite 700, Lewisburg, PA 17837**