Application for Transportation Services
(Persons with Disabilities (PwD), ADA, Senior Shared Ride-65+, Public Full Fare)

1. Transportation services may be available at a reduced rate, if you meet any of the following criteria:
   - Currently on Medical Assistance through the Department of Human Services
   - A person with a disability between the ages of 18-64
   - A person who travels along a fixed route, but due to a disability cannot access it
   - Aged 65+

2. If you would like to apply, please complete the entire application for transportation services and send it with any copies of qualifying documents to the address below.
   Capital Area Transit
   901 N Cameron St.
   Harrisburg, PA 17101

3. Applications are processed in the order that they are received
4. For ADA customers, if we have not processed your application within 21 days of receipt, you will be given presumptive eligibility until we are able to make an eligibility determination.
5. Incomplete or missing information or documents will delay processing
6. Once processed, a representative will contact you to notify you of your eligibility the following way:
   ___ Phone Call   ___ Mail regular print size   ___ Mail large print size

If you have any questions or need this application in an alternate means, please call CAT Shared Ride (717) 232-6100 or Toll Free 1 800 303-1904

NOTE: The information provided in this application regarding your age, disability, and county of residence will be used to determine your eligibility for shared ride transportation services under the Rural Transportation for Persons with Disabilities and Senior Shared Ride programs.

Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and provide you with the appropriate referral service (MATP, ADA, MD/IDD). This information is kept confidential and is used by the professionals used only by the professionals involved in evaluating your eligibility.

Please Print
Ecolane ID: ____________

How did you first learn about Capital Area Transit paratransit system?

___ Hospital/Clinic Flyer   ___ Saw a Bus
___ Friend/Family Member   ___ Senior Center
___ Case Worker   ___ Advertisement: (Publication)
___ CAT Information Booth/ Outreach   ___ Other: (Specify)

GENERAL / QUALIFYING QUESTIONS

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
<th>Last Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>SSN:</td>
<td>Age:</td>
</tr>
</tbody>
</table>

Current address:

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip code:</th>
<th>Email:</th>
</tr>
</thead>
</table>

Home Phone:  | Cell Phone: | County: |
|-------------|------------|--------|

Emergency Contact: | Relationship: | Phone #: |
|-------------------|--------------|---------|
NEEDS ASSESSMENT
What is your primary language?
Do you have a medical assistance card?  ___ Yes ___ No
Do you have a vehicle in the household?  ___ Yes ___ No  Who owns the vehicle?
Do you have a disability according to the Americans w/ Disabilities Act (ADA)? If yes, attach the Certification of Disability Form
Do you have any mobility devices such as…
___ Manual Wheel Chair  ___ Oxygen  ___ Cane
___ Motorized Scooter  ___ Power Wheel Chair  ___ Walker
___ Crutches  ___ Guide Dog  Other ____________________
Do you require the services of a personal care assistant or escort when you travel? (Someone that is needed to assist you during the trip or at the origin or destination)  ___ Yes ___ No ___ Sometimes

AGE VERIFICATION: Please send a legible photo copy of one of the listed forms of proof of age along with this application
_A Medicare card is not an acceptable proof of age_. Please check which verification you are enclosing.
___ Armed forces discharge/separation papers  ___ Pennsylvania ID card
___ Passport/naturalization papers  ___ Photo motor vehicle driver’s license
___ Baptismal certificate  ___ Birth certificate (Maiden Name) ______________________
___ PACE ID Card  ___ Veteran’s Universal Access ID Card
___ Statement of age from U.S. Social Security Office  ___ Resident Alien Card

CURRENT TRAVEL
Do you currently use Capital Area Transit fixed route bus services?  ___ Yes ___ No ___ Sometimes
Does the weather affect your ability to use Capital Area Transit fixed route bus service?  ___ Yes ___ No ___
If yes, please explain:
List your most frequent destinations and how you get there now
Destination address where you go
How often do you go there?
How do you get there?
1. 
2. 

DUPLICATION OF TRANSPORTATION SERVICES
Do you currently receive any transportation services?  ___ Yes ___ No
Are any of your transportation costs paid for by another program or organization? (Select from below all that apply)
___ Senior Citizens Shared Ride Transportation Program  ___ Office of Vocational Rehabilitation (OVR)
___ Medical Assistance Transportation Program  ___ Mental Health/Mental Rehabilitation (MH/IDD)
___ Americans w/Disabilities Act Complementary Paratransit  ___ Area Agency on Aging
___ Group Home (Where you live)  ___ Other ______________________

ENVIRONMENT AROUND YOUR RESIDENCE
How many steps are there at the entrance you use at your residence?
Can you get to a vehicle without the help of another person?  ___ Yes ___ No
How would you describe the terrain where you live?:  ___ Steep  ___ Hill  ___ Paved Lane  ___ Unpaved lane
Are there sidewalks in your neighborhood?  ___ Yes ___ No

DEMOGRAPHIC INFORMATION The following information is not required for Shared Ride to sponsor 85% of your trip fare. This information is required by the Offices for Aging, Inc. for reporting purposes.
Ethnic Information:
White ___ African American ___ Am Indian/Alaskan Native ___ Asian American/Pacific Islander ___ Hispanic Origin ___ Other ___
Do you live alone?  ___ Yes ___ No
Do you have adequate housing?  ___ Yes ___ No
INCOME AND HOUSEHOLD RELATED DATA

If you are NOT registered for the Medical Assistance Transportation Program (MATP), you may qualify, and this program could pay all of the cost for your eligible trips to medical appointments.

After reviewing the chart below I think that...

_____ I’m already registered with MATP   _____ I may qualify for MATP   _____ I do not think I qualify for MATP

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

2016 POVERTY GUIDELINES

<table>
<thead>
<tr>
<th>Household Size (select one)</th>
<th>Annual Income (select one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>less than $11,770</td>
</tr>
<tr>
<td>3</td>
<td>$11,771 - $17,930</td>
</tr>
<tr>
<td>4</td>
<td>$17,931 - $23,985</td>
</tr>
<tr>
<td>5</td>
<td>$23,986 - $29,425</td>
</tr>
<tr>
<td>6</td>
<td>$29,426 - $30,135</td>
</tr>
<tr>
<td>7</td>
<td>$30,136 - $39,825</td>
</tr>
<tr>
<td>8</td>
<td>$39,826 - $42,615</td>
</tr>
<tr>
<td>9</td>
<td>$42,616 - $48,500</td>
</tr>
<tr>
<td>10</td>
<td>$48,501 - $55,095</td>
</tr>
<tr>
<td>11</td>
<td>$55,096 - $60,625</td>
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<td>12</td>
<td>$60,626 - $65,140</td>
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<td>15</td>
<td>$81,426 - $85,230</td>
</tr>
<tr>
<td>16</td>
<td>$85,231 - $91,825</td>
</tr>
<tr>
<td>17</td>
<td>$91,826 - $97,710</td>
</tr>
<tr>
<td>18</td>
<td>$97,711 - $102,225</td>
</tr>
<tr>
<td>19</td>
<td>$102,226+</td>
</tr>
</tbody>
</table>

MEDICAL ASSISTANCE INFORMATION (if applicable)

Access Card # ________________________
Recipient # ________________________
Card Issue # ________________________

Do you receive any of the following services?

_____ Methadone    _____ Dialysis   _____ STAP-Camp Name
_____ After School Services     _____ Other_______________________

RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION

I certify that the information contained in this application is correct and truthful to the best of my knowledge. I understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by Capital Area Transit.

I give my permission to Capital Area Transit to contact a healthcare or other professional that I designate for additional information to verify that I am a person with a disability. ___Yes ____ No

By signing below, I hereby agree to report any changes in circumstances immediately to this Service Provider regarding my eligibility for funding assistance. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services hearing. This affirmation statement covers this application and all attachments required for the determination of eligibility. I am authorizing that, in the event that the Service Provider must verify information regarding my trips from medical providers to which I am traveling, in order to comply with the PA Department of Human Services regulations, you have my permission to do so. The information will be held by only the Service Provider and its agents in the strictest confidence and will not be shared with any other agency, except the professionals from which we are receiving the information.

Your signature (or name person who completed this form) __________________________________________
Date:__________________________          Relationship:__________________________ Contact Number:___________________

MAILING INSTRUCTIONS: Please check the following before mailing your application

_____ Include a copy of ONE form of proof of age
_____ Include a copy of any other important documents such as the Certification of Disability Form
_____ Sign the Release of information and Certification of Application section
MOBILITY FUNCTIONAL ASSESSMENT
For each below question, check one answer. Your answers should be based on: how you feel most of the time; under normal circumstances; using your mobility equipment; and whether you can perform this activity independently.

Without the help of someone else, can you:

Walk up and down three steps if there are handrails on both sides? ___Always ___Sometimes ___Never ___Unsure

Use the telephone to get information? ___Always ___Sometimes ___Never ___Unsure

Cross the street, if there are curb cuts? ___Always ___Sometimes ___Never ___Unsure

Ride up and down a wheelchair lift with handrails on both sides? ___Always ___Sometimes ___Never ___Unsure

Find your way to the bus stop, if someone shows you the way? ___Always ___Sometimes ___Never ___Unsure

Currently travel by yourself? ___Always ___Sometimes ___Never ___Unsure

Wait 10 minutes in good weather outdoors without a place to sit? ___Always ___Sometimes ___Never ___Unsure

Step on and off the curb from a sidewalk? ___Always ___Sometimes ___Never ___Unsure

Travel up or down a gradual hill on the sidewalk, in good weather? ___Always ___Sometimes ___Never ___Unsure

Travel 3 level blocks, on the sidewalk, when the weather is good? ___Always ___Sometimes ___Never ___Unsure

If you are able to do this, how long does it take you? __< 5 min __5 – 10 min __> 10 ___Unsure

Have you ever gotten lost when traveling alone? ___Yes ___No

If the weather is good and there are no barriers in the way, what is the farthest you can walk or travel outdoors on a level sidewalk, using your mobility aid? (Please select the box which most closely your answer)
___ I cannot travel alone ___ Less than 1 block ___ 3 blocks ___ 6 blocks
___ Curb in front of house ___ 9 blocks ___ More than 9 blocks ___ Other ___________

Have you ever received training to learn how to use the bus or travel around the community? ___Yes ___No

If yes, which agency or person provided the training? ___Yes ___No

When were you trained?

Did you successfully complete the training? ___Yes ___No ___No, if not, why not?

Was your training route specific? ___Yes ___No ___Which routes did you learn?

Would you like to participate in training to learn to ride the bus? ___Yes ___No

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY
In order to be eligible based on a disability, the Certification of Disability (last page) must be completed by a qualified individual from one of the organizations listed below that you are a person with a disability is required to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.

Office of Vocational Rehabilitation (OVR) Bureau of Blindness and Visual Services Registered Nurse

Disability Insurance (SSDI) United Cerebral Palsy PA Attendant Care Program Physician

Community Services Program for Persons with Physical Disabilities Registered Physical/Occupational Therapist

Mental Health/Mental Retardation Program (MH-MR) Center for Independent Living (CIL) Other ___________

Information contained in this application will be kept confidential and shared only with professionals involved in evaluating your eligibility and appropriate Capital Area Transit personnel. Capital Area Transit staff may need to talk to the applicant later to get more information.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ___Yes ___No ___No, I am already registered to vote where I live now.
PERSONAL CARE ASSISTANT FORM

APPLICANT – PLEASE COMPLETE THE TOP PORTION OF THIS FORM

Date: __________________________

Name of applicant:

Last  First  MI

Address:

Street  City  State  Zip

Are you able to use the fixed route bus?  Yes _____  No _____

Do you require curb to curb service?  Yes _____  No _____

Do you require an escort when you travel?  Yes _____  No _____

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE SECTION BELOW

The person’s disability can generally be described as (please print or type information): ______

______________________________________________________________________________

______________________________________________________________________________

1. The disability will last longer than twelve months

2. The disability is temporary and can be expected to last until _____ / _____

Month  Year

Under what conditions is an escort required? _______________________________________

______________________________________________________________________________

Name of physician: ____________________________________________________________

Address: _____________________________________________________________________

______________________________________________________________________________

Phone No.: ___________________________________________________________________

Physician’s Signature: __________________________________________________________________

WHEN PROPERLY COMPLETED, PLEASE MAIL OR FAX TO:

SHARED RIDE CUSTOMER SERVICE  FAX NO. 717 232-6973
Capital Area Transit
901 N. Cameron St
Harrisburg, PA. 17101
Certification of Disability Form
Reduced Fare Transportation Services
Transportation for Persons with Disabilities (PwD) and ADA Program

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 professional 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 Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by Central Pennsylvania Transportation Authority. If you have any questions about the form, please call Capital Area Transit Shared Ride (717) 232-6100 Toll Free 1 800 303-1904

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 or Applicant Representative signature: ___________________________ Date: ______________________

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disabilities 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.

How many blocks can this person walked unassisted? (Circle One) <1 block 1-2 blocks 2-3 blocks 6 blocks 9 blocks

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

_____ Guide/Service Dog _____ White Cane

_____ Requires Personal Assistant (nurse, health aide, etc.)

_____ Requires Escort

Signature of Professional: ___________________________ Date: ______________________

Title: ___________________________ Name of Agency or Organization: ___________________________

Address: ___________________________ Telephone: ___________________________

 Please send completed form to:
Capital Area Transit
910 N Cameron St, Harrisburg, PA. 17101