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 of 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			
First Name:	Middle Name:		Last Name:
Date of birth:	SSN:		Age:
Current address:			
City:	State:	Zip code:	Email:
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			
Household Size (select one)	**Annual Income (select one)**		
___1 ___ 2	___ less than $11,770	___$11,771 - $17,930	___$17,931 - $23,985
___ 3 ___ 4	___ $23,986 - $29,425	___$29,425 - $30,135	___$30,136 - $39,825
___ 5 ___ 6	___ $39,826 - $42,615	___$42,615 - $48,500	___$48,501 - $55,095
___ 7 ___ 8	___ $55,096 - $60,625	___$60,626 - $65,140	___$65,141 - $71,025
	___ $71,026 - $81,425	___$81,426 - $85,230	___$85,231 - $91,825
	___ $91,826 - $97,710	___$97,711 - $102,225	___$102,226+

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 professionals 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? When were you trained?

Did you successfully complete the training? ___Yes ___ No If no, 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