

**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