PIKE COUNTY TRANSPORTATION OFFICE
PERSONS WITH DISABILITIES PROGRAM – PWD

Reduced fare transportation services may be available to you if you are:

- A person with a disability
- Age 18-64
- Live in Pike County

If you would like to participate in this Program or have any questions, please complete the following application and forward to:

PIKE COUNTY TRANSPORTATON OFFICE
506 BROAD STREET
MILFORD, PA 18337
570-296-3408 PHONE
570-296-3409 FAX
1-866-681-4947

The information provided in this application regarding your disability will be used to determine your eligibility for reduced fare transportation services under the PWD Program. 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 a professional involved in evaluating your eligibility and in analyzing the program for future recommendations.

PLEASE PRINT

Client Last Name _____Client First Name _____ M/F _____

Mailing Address _____

Physical Address _____

Name of Development/Community _____

Directions to Residence _____

_____

Date of Birth _____ Social Security Number _____

Proof of Age: Copy of Document with Name and Date of Birth

Telephone Number _____ Cell Phone Number _____

Emergency Contact Name _____ Emergency Contact Number _____

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?
____ Y____N

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.

WRITTEN VERIFICATION

Written verification by a knowledgeable organization or qualified individual that you are a person with a disability is required to participate in the PWD Program.

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

____Social Security Disability SSD

____Bureau of Blindness & Visual Services

____Center for Independent Living (CIL)

____Mental Health/DS

____United Cerebral Palsy

____Registered Physical/Occupational Therapist

____Physician

____Registered Nurse

____PA Attendant Care Program

____Community Services Program for the Person

____Other _____

NO WRITTEN VERIFICATION

Please fill out the following certification of disability form. It provides verification of a disability according to the definition in the American with Disabilities Act (ADA). This form can be used to acquire the necessary information for verifying a disability from a qualified health professional.

INFORMATION TO SERVE YOU BETTER

Is your disability permanent (more than 12 months)? ____Y _____N
Standard definition of a permanent disability is one that lasts 12 months.

If not, how long _____

What is the nature of your disability? Please check those that apply.

____Mobility disability

____Vision disability

____Hearing disability

____Cognitive disability

____Mental disability

____Other-Please specify _____

Please check all mobility aids that apply:

____ Manual wheelchair

____Power wheelchair

____Motorized Scooter

____Crutches

____Cane

____Walker

Is there anything else you want us to know so we can serve you better? _____Y _____N

If YES, please describe _____

_____

_____

Do you require the services of a personal care attendant or escort when you travel? (Someone that is needed to assist you during the trip or at the origin or destination)_____ Yes _____No
Describe when you need the assistance:_____
_____
_____

If so, please complete the escort application and return.

ESCORT POLICY AND APPLICATION

An escort is an individual that shall accompany a client to his or her appointment. Based on physical, medical or mental conditions, certain clients may be required to have an escort of their choice ride with them. This is for the safety and well being of the client and is the sole responsibility of the client.

The escort may not be employed by or provided by the Transportation Office delivering the transport and must be registered with the Transportation Office.

The Transportation Office needs to be notified as soon as possible, should an escort change and that a new escort will be assuming these responsibilities. The new escort must complete an application and provide requested documentation.

The client is responsible to make sure that their escort has submitted the completed escort application before transportation services are provided.

The client is responsible to notify the Transportation Office of any changes in escorts.

An escort must be either a parent, legal guardian, foster parent and all others 25 years of age or older.

All escorts are responsible to submit the escort application along with proof of identification.

ALL ESCORTS ARE REQUIRED TO FILL OUT THE APPLICATION BELOW AND RETURN

Client's Name _____

Escort's Name _____Date _____

Address _____

Phone _____ Cell Phone _____

Emergency Contact _____

Agency Affiliation _____

Escort Signature _____

A copy of the following identification is required to be submitted with this application:

Pennsylvania ID
or
Pennsylvania Driver's License

INCOME & HOUSEHOLD DATA

Client income related data is being collected for further decision-making regarding the program. This information will not be used to determine eligibility for discounted fares under the PWD Program.

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

Please review the chart below and complete the following. If you think you may qualify, we will contact you with more information.

____I am already registered with MATP Provide Recipient # _____

____I think I may qualify for MATP Call County Assistance Office 570-296-6114

____I do not think I qualify for MATP

Household size	Annual Income
1	____ $14,363 - $19,387
2	____ $19,388 - $24,412
3	____ $24,413 - $29,437
4	____ $29,438 - $34,462
5	____ $34,463 - $39,487
6	____ $39,488 - $44,512
7	____ $44,513 - $49,537
8	____ $49,538 – over

For each additional member of the household in excess of 8 add $5,025.

AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the PWD Program are not to be provided in place of any current transportation services that you already receive.

Do you currently receive any transportation services or are any of your transportation costs paid for by another program or organization (choose one)?____Yes ____No

____Senior Citizens Shared-Ride Transportation Program

____Area Agency on the Aging

____Medical Assistance Transportation Program (MATP)

____American with Disabilities Act Complementary Paratransit

____Mental Health/Developmental Services

____Office of Vocational Rehabilitation

____Group Home where you live

____Other_____

I understand that the purpose of this application is to determine if I am eligible to participate in the PWD Program.

I certify that the information contained in this application is correct and truthful to the best of my knowledge.

Signature of Applicant_____

Date _____

CERTIFICATION OF DISABILITY FORM
PERSONS WITH DISABILITIES PROGRAM (PWD)
PLEASE FORWARD BACK WITH APPLICATION IF NECESSARY

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 American's with Disabilities Act. (ADA) 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, provides cognitive transportation services, 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 Local Service Provider. If you have any questions about this form, please contact The Pike County Transportation Office at 570-296-3408.

Applicant Information (to be completed by applicant)
Client Last Name _____ Client First Name _____ M/F/_____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ email _____

_____ _____
Signature Date

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?
Mobility disability _____Vision disability _____Hearing disability _____ Cognitive disability _____
Mental disability _____ Other-Please specify _____

Please check those that apply and all mobility aids that apply.
Manual wheelchair ____ Power wheel chair _____Motorized Scooter ____ Crutches ____ Cane ___ Walker _____

_____ _____
Print of Professional Signature of Professional

_____ _____
Title Date

_____
Name of Agency or Organization

_____
Address

_____
Phone Number