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 TRANSPORTATION 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.
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

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

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                                                                                               

UPDATED 6/2013