Eligibility and Registration Form
Transportation for Persons with Disabilities (PwD) Program

◆ Reduced fare transportation service may be available to you if you are:
1. A person with a disability and.
2. Age 18 - 64 and.
3. Need accessible public transit in a participating county beyond ADA complementary paratransit services.

◆ If you would like to participate in this program, please complete this form and send it with a copy of one of the documents listed in Part 2 below to:

FULTON COUNTY FAMILY PARTNERSHIP, INC.
22438 Great Cove Road
McConnellsburg, PA 17233

◆ Once your application is received and reviewed you will be notified of your eligibility to participate.

◆ If you have questions about this project, this form or need this form in an alternate format please call:
717-485-0931

Note: 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 professionals involved in evaluating your eligibility and in analyzing the program for future recommendations. Please print clearly.

PART 1: GENERAL

Last Name: _____ First Name:_____ M.I.:_____

Address (Street & No.): _____

City: _____ State:_____ Zip Code: _____

Telephone: Home:_____ Work: _____ Cell _____

E-mail: _____

County of Residence: _____ Date of Birth: _____

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

Definition of Disability
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."

PART 2: WRITTEN VERIFICATION THAT YOU ARE A PERSON WITH A DISABILITY

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.

1. If you have written verification of a disability:

You may already have written verification that you are a person with a disability from a service organization by having an identification card, a written assessment of your disability, etc. If so, send a copy of this information to FCP If not, you will need to ask an organization or individual listed below to verify, in writing, that you are a person with a disability according to the ADA definition and then send it to Fulton County Family Partnership,Inc.

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) and Disability Insurance (SSDI)
_____ Bureau of Blindness and Visual Services
_____ Center for Independent Living (CIL)
_____ Mental Health/Mental Retardation Program
_____ United Cerebral Palsy
_____ Registered Physical/Occupational Therapist
_____ Physician
_____ Registered Nurse
_____ PA Attendant Care Program
_____ Community Services Program for Persons with Physical Disabilities
_____ Other: _____

_____

2. If you do not have written verification of a disability:

Please fill out the attached Certification of Disability Form (Attachment A). It provides verification of a disability according to the definition in the Americans with Disabilities Act. This form can be used to acquire the necessary information for verifying a disability from a qualified health professional.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

Passenger income related data is being collected for further decision-making regarding the program. Complete this section only if you plan to use the PwD program for **medical** trips. THIS INFORMATION WILL NOT BE USED TO DETERMINE ELIGIBILITY FOR DISCOUNTED FARES UNDER THE PwD PROGRAM. Please check the appropriate space in each column:

Annual Income

_____ Less than $10,000
_____ $10,001-$15,000
_____ $15,001-$20,000
_____ $20,001-$25,000
_____ $25,001-$30,000
_____ $30,000-$35,000
_____ $35,001-$40,000
_____ $40,001-$45,000
_____ $45,001-$50,000
_____ $50,001-$55,000
_____ $55,001-$60,000
_____ $60,001+

Household Size

_____1
_____2
_____3
_____4
_____5
_____6
_____7
_____8 +

PART 4: 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.

1. Do you now receive any transportation services or are any of your transportation costs paid for by another program or organization? Please complete all that apply from the following list. (This information does not automatically exclude you from eligibility for the PwD program.)

_____ Senior Citizens Shared-Ride Transportation Program
_____ Area Agency on the Aging
_____ Medical Assistance Transportation Program
_____ Americans with Disabilities Act Complementary Paratransit
_____ Mental Health/Mental Retardation (MH/MR)
_____ Office of Vocational Rehabilitation (OVR)
_____ The training program I am in at _____
_____ The employment program I am in at _____
_____ The residential program where I live.
_____ Other (please explain) _____

2. If you are not registered for Medical Assistance (MA), you may qualify. If appropriate, you will be referred to the County Assistance Office (CAO) for a determination of eligibility for MA and other programs.

_____ Applicant was informed of pending referral to the County Assistance Office (CAO)

_____ Applicant was referred to the CAO for MA eligibility determination on (date):_____

Initials of TransNet staff person initiating the referral to the CAO ____

PART 5: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent? ____ Yes ____No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.)

2. If not, how long is it expected to last? _____

3. What is the nature of your disability? Check those that apply. (See Attachment B for Categories of Disabilities)

_____ Mobility disability (please see question 4 below)
_____ Vision disability
_____ Hearing disability
_____ Cognitive disability
_____ Mental disability
_____ Other — Please specify: _____

4. Please check all mobility aids that apply.

_____ Manual wheelchair _____ Crutches _____Guide/Service Dog
_____ Power Wheelchair _____ Cane _____White Cane
_____ Motorized Scooter _____ Walker

5. Do you require the services of a personal care attendant or escort when you travel? (A personal care attendant or escort is a person that you need to assist you during the trip or at your origin or destination)

_____ Yes

_____ No

_____ Sometimes

Please describe when you need assistance: _____

_____

_____

6. Emergency Contact (Optional)

Name: _____

Relationship: _____

Phone (Home):_____ (Work)_____ (Cell)_____

7. Is there anything else you want us to know so we can serve you better? ____ Yes ____ No

If "Yes," please describe: _____

_____

_____

_____

_____

_____

PART 6: RELEASE OF INFORMATION and YOUR CERTIFICATION OF THE APPLICATION FORM

I give my permission to Fulton County Partnership, Inc. to contact a health care or other professional that I designate for additional information to verify that I am a person with a disability.

Yes _____ No_____

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.

_____

Applicant's Signature Date

OR

_____

Representative's Name (Please Print) Relationship to Applicant Telephone number

_____

Representative's Signature Date

Certification of Disability Form

Reduced Fare Transportation Services
Transportation for Persons with Disabilities (PwD) 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 ***HBF Area Agency on Aging***. If you have any questions about the form, please call **717-485-0931.**

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 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."

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? 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:
FULTON COUNTY FAMILY PARTNERSHIP, INC.
22438 Great Cove Road
McConnellsburg, PA 17233