***Eligibility and Registration Form Rural 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 age 18 – 64 and
2. Needs accessible public transit in Bucks 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:

Bucks County Transport, Inc.
P.O. Box 510
Holicong, PA 18928
Or
FAX 215-794-5564

◆ Once your application is received and reviewed you will be notified of your eligibility to participate.
◆ If you have questions about this program, this form or need this form in an alternate format please call:
1-888-795-0740

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 pilot 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:_____ Cell: _____ E-mail: _____

County of Residence _____ Date of Birth: _____ SSN#:_____
Is your residence considered a Group Home or other Community Residential facility?
_____Yes _____No
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."

DO NOT FILL OUT THIS SECTION – BCT STAFF ONLY

PwD Status:_____ MA Status:_____

Spec. Nds:_____ Emerg. Contact_____

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, attach a copy of that information to this form. 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 back to Bucks County Transport, Inc. (Address is on Page 1). See # 2 below.

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/Developmental 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 a Certification of Disability Form, Attachment G, Page 6. 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. THIS INFORMATION WILL NOT BE USED TO DETERMINE ELIGIBILITY FOR DISCOUNTED FARES UNDER THE PwD PROGRAM. Please check the appropriate space in each column:

Applicant 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.

_____None/Does not apply – Skip to Part 5
_____ Senior Citizens Shared-Ride Transportation Program
_____ Area Agency on the Aging
_____ Medical Assistance Transportation Program
_____ Americans with Disabilities Act Complementary Paratransit
_____ Mental Health/Developmental Program (MH/DP)
_____ Office of Vocational Rehabilitation (OVR)
_____ Managed Care Organization (MCO)
_____ The training program I am in at _____
_____ The employment program I am in at _____
_____ The Residential Program where I live _____
_____ Other (please explain) _____

Note: Checking multiple blocks above should not disqualify your eligibility for the PwD Program.

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.

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.

_____ 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
_____ Power Wheelchair _____ Cane
_____ Motorized Scooter _____ Walker

All wheelchairs must be in functioning order and must meet certification requirements of BCT in advance of transportation. If a wheelchair becomes non-functioning while in transit, BCT will request assistance from the client's emergency contact or will contact 911 for emergency professional assistance at the client's expense.

5. Do you require the services of a personal care attendant or escort when you travel? If so, you must have a note from your medical professional stating that you require an escort. If an escort is required, the escort will ride at no charge.

_____ Yes

_____ No

_____ Sometimes

Please describe when you need assistance: _____

6. Will a trained service animal be required to accompany you on your transportation trips?

_____ Yes

_____ No

If so, what type of animal _____

7. Emergency Contact

Name: _____

Relationship: _____

Phone (Home): _____ (Work): _____

8. Please check all the destinations that apply to your transportation needs:

_____ Medical Appointments _____ Food Shopping _____ Other (Explain)
_____ Recreational _____ Employment

9. Please check an estimate of how many trips you plan to schedule per week:

_____ 1-2 per week _____ 2-5 per week _____ 6 or more per week

PART 6. CERTIFICATION OF THE APPLICATION FORM

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

Signature of Applicant_____ _____DATE _____

OR, WITH THE APPLICANT'S PERMISSION

Signature of the person who completed this form _____ DATE _____

Print Name of the person who completed this form _____

Relationship to Applicant _____

Attachment F

Release of Information

1. I _____ (Name of Applicant) do authorize _____(Name of Health Care Provider) to disclose to Bucks County Transport, Inc. such limited information from my medical records as is necessary to verify my disability for the specific and sole purpose of determining my eligibility for the PwD program.

This authorization will remain in effect for one year from the date signed unless revoked by me in writing. However, I understand that any actions taken in reliance of this authorization prior to receipt of my written revocation cannot be undone and are not in violation of law.

I further understand that there is a potential for information disclosed pursuant to this authorization to be disclosed by the recipient without the protections afforded by law and the covered entity to whom this authorization is directed cannot be liable for any further disclosures.

Signature of Applicant_____ Date_____

Attachment G

Certification of Disability Form
Reduced Fare Transportation Services

Rural 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 Rural Transportation for Persons with Disabilities (PwD) Program, which is being administered by the Pennsylvania Department of Transportation with services provided by **Bucks County Transport, Inc.** If you have any questions about the form, please call **1-888-795-0740.**

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 signature or that of the person who completed this form _____ 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

_____
Signature of Professional Date

_____
Title Name of Agency or Organization

_____
Address Telephone

Please send completed form to: ***Bucks County Transport, Inc.***
P. O. Box 510
Holicong, PA 18928
Or fax to 215-794-5564