



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

- Reduced fare transportation 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 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. Mail to:

Lebanon Transit
ATTN: PWD Program
200 Willow Street Lebanon, Pa 17046

- Once your application is received and reviewed you will be notified of your eligibility to participate
- If you have any questions about this program, this form, or need this form in an alternate format, (large print) please call 717-274-3664 or for TTY/TDD please call 1-800-654-5984

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 assessing the program for future recommendations.

PLEASE PRINT CLEARLY.

PART 1: GENERAL INFORMATION

Date of Application: _____

Last Name: _____ First Name: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Telephone # Home: _____ Work/ Mobile # _____

Date of Birth: _____ Social Security #: _____

Please provide physical address if different from mailing address:

Please provide clear instruction to your home (mandatory)

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 PwD Program.

1. If you have a 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 LT. 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 LT.

Please check the organization or individual whose written verification you are submitting with your application form.

- | | |
|--|---|
| <input type="checkbox"/> Office of Vocational Rehabilitation (OVR) | <input type="checkbox"/> Registered Physical/Occupational Therapist |
| <input type="checkbox"/> Social Security Insurance (SSI) and Disability Insurance (SSDI) | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Bureau of Blindness and Visual Services | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Center of Independent Living (CIL) | <input type="checkbox"/> PA Attendant Care Program |
| <input type="checkbox"/> Mental Health/Mental Retardation Program | <input type="checkbox"/> Community Services Program for person with Physical Disabilities |
| <input type="checkbox"/> United Cerebral Palsy | <input type="checkbox"/> Other: _____ |

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

Please fill out the Certification of Disability Form attached to this form. 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.
See Exhibit F in this package.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

Passenger income related data is being collected for further decision-making regarding the project. **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

- \$0-\$29,175.00
- \$29,175.01-\$39,325.00
- \$39,325.01-\$49,475.01
- \$49,475.01-\$59,625.00
- \$59,625.01-\$69,775.00
- \$69,775.01-\$79,925.00
- \$79,925.01-\$90,075.00
- \$90,075.01-\$100,225.00

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 check all that apply from the following list:

- Senior Citizens Shared-Ride Transportation Program
- Area Agency on Aging
- Americans with Disability Complementary Para-Transit
- Mental Health/Mental Retardation (OVR)
- Group home where you live
- Other (please specify) _____

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.

- I have been informed of *pending referral* to the Lebanon County Assistance Office
- I was referred to the CAO eligibility determination on (date): _____
- Initials of staff person faxing 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 all 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
- Electric Wheelchair
- Motorized Scooter
- Crutches
- Cane
- Walker

5. Do you require the services of a personal care attendant or escort when you travel?

- Yes
- No
- Sometimes

Please describe when you need assistance:

6. Emergency Contact

Name: _____ Relationship _____

Phone (Home): _____ (Work) _____

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 CERTIFICATION OF THE APPLICATION FORM

I give my permission to LT 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

Your Signature or the Person Who Completed This Form

Date

I understand that the purpose of this application is to determine if I am eligible to participate in the PwD project. I certify that the information contained in this application is correct and truthful to the best of my knowledge.

Your Signature or the Person Who Completed This Form

Date

If someone other than the applicant completed this form, please complete the following:

Print Name: _____

Relationship to applicant: _____

Telephone number: _____

Medical Assistance Transportation Program-Eligibility Guidelines

In keeping with the maintenance of effort policy of the PwD Program, transportation providers and their subcontractors, if appropriate, are required to refer Medical Assistance Transportation Program (MATP) eligible clients to that program for funding for their medical trips.

The County Assistance Office (CAO) provides individuals who are eligible for MA with an ACCESS card. Eligibility for MA and MATP is confirmed through the Department of Public Welfare's computerized Eligibility Verification System or EVS. All MATP providers are required to verify a client's MATP eligibility through EVS, which can be accessed by telephone, a point of sale device, or through an EVS provided computer disk. MATP eligibility verification information must be recorded.

If a transit provider is not the MATP coordinator, then the transit provider must request the MATP coordinator to check on a client's eligibility status through the EVS or the client must be referred to the CAO for an assessment of MA eligibility. The transit provider must notify the client of his/her referral to the CAO prior to making the actual referral.

Clients of the PwD Program, whose incomes indicate a possible eligibility for MA, must be referred to the CAO for a determination of eligibility for MA and other programs. A client who is determined eligible for MA is also eligible for the MATP. PwD providers must then refer them to the MATP for funding of their medical trips. Clients must also receive notification of the CAO referral in advance.

Documentation of Disabilities

The transit provider must obtain documentation of the disability as identified by the applicant.

All agencies should accept the eligibility determinations and documentation that have been prepared by organizations and programs that interact with the disability community. Examples of these agencies and programs include the following:

- Social Security Administration's SSI and SSDI eligibility determinations and supporting documentation such as a SSDI card.
- Office of Vocational Rehabilitation's (OVR) establishment of a mental or physical disability through its Comprehensive Medical Examination.
- Attendant Care Program qualifying disability: any medically determinable physical impairment that can be expected to last for a continuous period of not less than 12 months.
- A qualifying disability through the Community Services Program for Persons with a Physical Disability. A medically determinable condition, excluding primary diagnoses of mental retardation or mental illness, expected to continue indefinitely; and resulting in at least three of the following six substantial functional limitations: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
- The Certification of Disability form, which is **Attachment F**, provides verification that an applicant has a disability according to the definition in the Americans with Disabilities Act. If there is no organization available to provide the disability documentation, then the transit provider will use this form to acquire the necessary information for determining eligibility from a qualified medical provider.

Three Categories of Disabilities

Rural Transportation for Persons with Disabilities (PwD) Program

Disabilities are described in the following three categories:

1) Mental impairment, including development disabilities

- a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- b. Is likely to continue indefinitely;
- c. Results in substantial functional limitations in any of the following area of major life activities, self-direction, learning, mobility, economic self-sufficiency, self-care, capacity for independent living and receptive and expressive language;
- d. Causes the substantial diminished level of functioning in the primary aspects of daily living and inability to cope with the ordinary demands of life, attention impairment, cognition impairment, language impairment, memory impairment, conduct disorder or motor disorder.

2) Physical impairment

- a. Persons having a physical condition resulting from injury, disease, or congenital deficiency which significantly interferes with or limits one or more major life activities and affects one or more of the following body systems: anatomical, musculoskeletal, neurological, respiratory including speech organs, cardiovascular, reproductive, digestive, genitio-urinary, hemic and lymphatic, skin and endocrine;
- b. The term physical impairment includes but is not limited to such contagious or non-contagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease and tuberculosis.

3) Major life activities

- a. Activities relating to the performance of self-care and engaging in leisure or play activities; Self-care includes grooming, mobility, object manipulation, and ambulation;
- b. Activities relating to the ability to walk, see, hear, breathe, or communicate;
- c. Activities relating to moving about in one's community for purposes that include accessing and participating in vocational, educational, recreational and social activities in the community with other members of the community.

Attachment F

**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 PwD Program, which is being administered by the Pennsylvania Department of Transportation with services provided by the County of Lebanon Transit Authority. If you have any questions about the form, please call (717)274-3664.

Applicant information (to be completed by applicant):

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

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Home: _____ **Work/Cell** _____ **E-mail:** _____

Signature of Applicant

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 last for 12 months or longer.)

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

Please check all that apply.

<p>What is the nature of the applicant's disability?</p> <p><input type="checkbox"/> Mobility disability (see question to the right)</p> <p><input type="checkbox"/> Vision Disability</p> <p><input type="checkbox"/> Hearing Disability</p> <p><input type="checkbox"/> Cognitive Disability</p> <p><input type="checkbox"/> Mental Disability</p> <p><input type="checkbox"/> Other-Please specify: _____</p>	<p>Please check all mobility aids that apply:</p> <p><input type="checkbox"/> Manual Wheelchair</p> <p><input type="checkbox"/> Electric Wheelchair</p> <p><input type="checkbox"/> Motorized Scooter</p> <p><input type="checkbox"/> Crutches</p> <p><input type="checkbox"/> Cane</p> <p><input type="checkbox"/> Walker</p>
---	---

Signature of Professional **Date**

Title **Name of Agency or Organization**

Address **Telephone #**

Please send completed form to: Lebanon Transit 200 Willow St Lebanon, PA 17046

**Attachment
G**

250% of FGIP 2011 Federal Poverty Income Guidelines

Family Size	Monthly Limit	Annual Limit
1	\$2,431.25	\$29,175.00
2	\$3,277.08	\$39,325.00
3	\$4,122.92	\$49,475.00
4	\$4,968.75	\$59,625.00
5	\$5,814.58	\$69,775.00
6	\$6,660.42	\$79,925.00
7	\$7,506.25	\$90,075.00
8	\$8,352.08	\$100,225.00

Eligibility and Registration Form-Supporting Information

THE FOLLOWING FORMS ARE FOR INFORMATIONAL PURPOSE ONLY. ATTACHMENT B SHOULD BE USED IF THE APPLICATION DOES NOT HAVE WRITTEN VERIFICATION OF DISABILITY.

Medical Assistance Transportation Program (MATP) Eligibility Information

Documentation of Disabilities

Three Categories of Disabilities-Attachment A

- 1) Mental impairment, including development disabilities
- 2) Physical impairment
- 3) Major life activities

Forms Used for Determining Disability

- 4) Attachment F: Certification of Disability Form. To be used if an applicant has no written documentation of his/her disability.
- 5) Attachment G: Federal Poverty Income Guidelines

Note: As stated in Part 2, **if you have no other existing form of written verification**, the Attachment F: the PwD Program Certification of Disability form can also be used to verify that you have a disability. This form is to be returned to the Lebanon Transit. Please contact LT if there are questions.

**Lebanon Transit
Referral for Services
Authorization for Use or Disclosure of Personal Information**

1. I hereby authorize Lebanon Transit to obtain information pertaining to:

Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

_____ Telephone#: _____

2. Reason for disclosure: To qualify for Medical Assistance and/or other benefits available through the Pennsylvania Department of Public Welfare.

3. One application has been made at the Lebanon County Assistance Office; the date of the application will be disclosed by Lebanon County Assistance Office to:

Lebanon Transit

Date of DWP Benefits Application: _____

4. I understand that:

This authorization may be revoked at any time by writing to Lebanon Transit, except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosures.

The Department and its health and human services programs will not condition treatment, payment, enrollment or eligibility on the provision of authorization.

Information disclosed pursuant to this authorization may be subject to re-disclosure by the individual/organizations identified and is no longer protected by federal privacy regulations.

The Department, its programs, services, employees, officers and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I may refuse to sign this authorization; I understand that refusal may limit the availability of medical transportation benefits, which includes transportation services from the Lebanon Transit.

This authorization applies only to the extent and for reasons named above. It does not apply to any other agency, organization or reason other than that named above.

Signature of Individual or Personal Representative

Date

If Personal Representative, estate relationship to Individual

Signature of Witness (necessary only if individual is unable to sign)

Date