



lebanon transit

ADA PARATRANSIT APPLICATION

1. NAME: _____ DATE: _____
2. ADDRESS: _____
CITY _____ STATE: _____ ZIP: _____
3. HOME # _____ CELL # _____
4. BIRTHDATE: _____
5. LAST 4 DIGITS OF SOCIAL SECURITY #: _____
6. WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING OUR FIXED ROUTE SERVICES?

IS THE CONDITION TEMPORARY? ____ YES ____ NO IF YES, EXPECTED DISABILITY UNTIL: _____
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7. HOW DOES THIS DISABILITY PREVENT YOU FROM USING OUR FIXED ROUTE SERVICES? PLEASE EXPLAIN COMPLETELY, USE ADDITIONAL PAPER IF NECESSARY.
8. ARE THERE ANY OTHER EFFECTS OF YOUR DISABILITY WHICH WE SHOULD BE MADE AWARE OF?

9. DO YOU USE ANY OF THE FOLLOWING AIDS FOR MOBILITY?

<input type="checkbox"/> CANE	<input type="checkbox"/> CRUTCHES	<input type="checkbox"/> GUIDE DOG
<input type="checkbox"/> MANUAL WHEELCHAIR	<input type="checkbox"/> ELECTRIC WHEELCHAIR	

10. DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOUR TRAVEL USING TRANSIT? YES NO

11. PLEASE ANSWER THE FOLLOWING QUESTIONS.

CAN YOU TRAVEL 200 FEET WITHOUT ASSISTANCE? YES NO

CAN YOU TRAVEL 500 FEET WITHOUT ASSISTANCE? YES NO

CAN YOU TRAVEL 700 FEET WITHOUT ASSISTANCE? YES NO

CAN YOU TRAVEL ¼ MILE WITHOUT ASSISTANCE? YES NO

CAN YOU TRAVEL ¾ MILE WITHOUT ASSISTANCE? YES NO

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE? YES NO

12. I HERE CERTIFY THE INFORMATION GIVEN ABOVE IS CORRECT.

SIGNATURE

DATE

13. IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION PLEASE PROVIDE FOLLOWING INFORMATION:

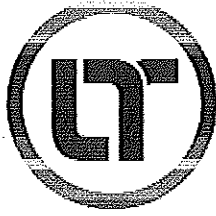
NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

14. THE ATTACHED MEDICAL RELEASE FORM MUST BE COMPLETED BY A LICENSED OR CERTIFIED HEALTH CARE PROFESSIONAL IN ORDER TO DETERMINE ELIGIBILITY FOR THE LT REDUCED FARE PROGRAM FOR PEOPLE WITH DISABILITIES.



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MEDICAL RELEASE FORM

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

I hereby authorize the Health Care Professional to release to the Lebanon Transit (LT) information about my disability.

Signature

Date

Health Care Professional info:

Name of Health Care Professional: _____

Phone: _____

Address: _____

City, State, Zip: _____

200 Willow St. Lebanon, PA 17046 Phone: (717)274-3664 Fax: (717)274-8860

Website: www.lebanontransit.org

DECLINATION FORM

Name (Please print: Last Name, First, M.I)

**IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW,
WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE
TODAY?**

Yes

No OR No, I am already registered to vote where I live now.

IF YOU DECIDE NOT TO CHECK A BOX, YOU WILL BE CONSIDERED TO
HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the account of
assistance that you will be provided by this agency.

If you apply to register to vote, the office at which you submit this registration
application form will remain confidential

No information relating to a declination to register to vote will be used for any purpose
other than for voter registration.

If you would like help filling out the voter registration applications form, we will help
you. The decision whether to seek or accept help is yours. You may fill out the
application form in private.

In order to be qualified to register to vote, you must be at least 18 years of age on the day
of the next election, you must have been a citizen of the United States for at least one
month prior to the next election and have resided in Pennsylvania and the election district
where you plan to vote for at least 30 days prior to the next election.

If you believe that someone has interfered with your right to register or in applying to
register to vote, or your right to choose your own political party preference, you may file
a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State,
302 North Office Building, Harrisburg, PA 17120, or call the Department of State, toll-
free, at 1-800-552-VOTE (8683).

Signature

Date