



SCHUYLKILL TRANSPORTATION SYSTEM

Application for Transportation Services

Persons with Disabilities (PwD), Americans with Disability Act (ADA), Senior Shared Ride 65+, Public Full Fare

Important

- All customers must complete parts 1, 4, 5, 6 & 7
- If you have a disability, please complete parts 2, 3 and the Voter Declination Form

1. Transportation services may be available at a reduced rate if you meet any of the following criteria:
 - a. Currently on Medical Assistance through the Department of Human Services. MATP can be reached at (570) 628-1425 or (888) 656-0700 (medical appointments only).
 - b. A person with a disability and aged 18-64.
 - c. A person who lives along the fixed route, but due to a disability is unable to access it.
 - d. Aged 65 or older and reside in Schuylkill County, please contact the Schuylkill County Office of Senior Services at 570-622-3103.

2. If you would like to apply, please complete this form and send it with a copy of the documents listed to the below address:

**SCHUYLKILL TRANSPORTATION SYSTEM
P.O. Box 67
Saint Clair, PA 17970**

3. Once your application is received and reviewed you will be notified of your eligibility to participate.
4. If you have any questions about this application please call:

Toll Free Phone: (800) 832-3322 or (570) 429-2701

NOTE: The information provided in this application regarding your age, disability, and county residence will be used to determine your eligibility for shared ride transportation services under the Rural Transportation for Persons with Disabilities and Senior Shared Ride programs.

Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and provide you with appropriate referral service (MATP, ADA, MH/IDD).

This information will be kept confidential and used only by the professionals involved in evaluating your eligibility.

Also included with your application is a Voter Declination Form. STS is required by Federal law to provide this form to all applicants applying for ADA Complementary Paratransit and Persons w/Disabilities Shared Ride Van programs and can be returned with your completed application. Your elections will not affect your eligibility.

PART 1: GENERAL / QUALIFYING QUESTIONS

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

*Address (Street and Number): _____

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

*Municipality _____

*County of Residence: _____ *Gender: _____

*Telephone: Home (_____) _____ Work (_____) _____

*Social Security Number _____ (Last 4 digits only) *Date of Birth _____ *Current Age _____

Acceptable proof of age documents (one required). Please send a legible photocopy of your proof of age along with this application. A Medicare card is not an acceptable proof of age.

- | | |
|---|--|
| 1) Armed forces discharge/separation papers | 6) Passport/naturalization papers |
| 2) Baptismal certificate | 7) Pennsylvania ID card |
| 3) Birth certificate | 8) Photo motor vehicle driver's license |
| 4) PACE ID card | 9) Veteran's Universal Access ID card |
| 5) Resident Alien Card | 10) Statement of age from U.S. Social Security Administrative Office |

***Emergency Contact**

Name: _____

Relationship: _____

Home Phone number: _____ Cell Number _____

***In order for us to serve you better, please check all that apply.**

Does the client need a lift van? _____ Yes _____ No

Does the client use a wheelchair? _____ Yes _____ No

(Is the wheelchair oversized?) _____ Yes _____ No

Does the client need an oxygen tank? _____ Yes _____ No

(Oxygen tank must be portable)

Does the client need an escort? _____ Yes _____ No

Start Date: _____	FOR OFFICE USE ONLY
Date Registered: _____	
Details last reviewed: _____	
Active: Yes or No: _____	
Reason Active: _____	
Status Date: _____	
End Date: _____	

SCTA Employee Signature verification of proof of age:

_____/_____/_____ / _____
SCTA Employee print name Signature Date

***Information required by the Schuylkill County Office of Senior Services**

PART 2: PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY

Do you have a disability according to the Americans w/ Disabilities Act (ADA)?

YES _____ NO _____

ADA definition of *disability*: "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."

In order to be eligible based on a disability, written verification by a qualified individual or organization that you are a person with a disability is **required** to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.

The more information you provide, the better we will be able to understand your ability and travel challenges. Information contained in this application will be kept confidential and shared only with the professionals involved in evaluating your eligibility and appropriate Schuylkill Transportation System personnel. Schuylkill Transportation System staff may need to talk to the applicant later to get more information.

As part of the application process, you will have the opportunity to register to vote if you wish.

You must provide documentation from either Section 2A or 2B.

Section 2A

_____ Enclosed Certification of Disability Form (**Preferred**)

Section 2B

You will need to send verification from one of the organizations or persons listed below. Please check which verification you are enclosing.

- _____ Office of Vocational Rehabilitation (OVR)
- _____ Disability Insurance (SSDI)
- _____ Bureau of Blindness and Visual Services.
- _____ Center for Independent Living (CIL)
- _____ Intellectual Development Disability (IDD) aka Mental Health/Mental Retardation
- _____ United Cerebral Palsy
- _____ Registered Physical/Occupational Therapist
- _____ Physician
- _____ Registered Nurse
- _____ PA Attendant Care Program
- _____ Community Services Program for Persons with Physical Disabilities
- _____ Other _____

PART 2A: Certification of Disability Form

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 persons with disabilities. The applicant has applied for transportation services under the Persons with Disabilities (PwD) or ADA program, which is being administered by the Pennsylvania Department of Transportation with services provided by the Schuylkill Transportation System. If you have any questions about the form, please call 570-429-2701 or 800-832-3322.

Applicant Information (to be completed by the applicant):

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

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, speaking, breathing, learning, and work.”

Please answer the following questions (to be completed by the agency or person providing verification of eligibility information)

What is the disability that prevents the applicant from using Schuylkill Trans. bus service? _____

How many blocks can this person walk unassisted? (circle one) <1 1-2 2-3 6 9

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 do you expect the applicant to have this disability? _____

Does the disability change much from day to day? _____ Yes _____ No

What is the nature of the applicant’s disability? Check those that apply

Please check all mobility aids that apply

_____ Mobility disability (please see question to the right)

_____ Manual Wheel Chair _____ Crutches

_____ Vision disability

_____ Power Wheel Chair _____ Cane

_____ Hearing disability

_____ Motorized Scooter _____ Walker

_____ Cognitive disability

_____ Dog Guide _____ Oxygen

_____ Mental disability

_____ Other: _____

_____ Other – Please specify: _____

Signature of Professional

Printed Name

Date

Title

Name of Agency or Organization

Address

Telephone Number

PART 3: ADA FUNCTIONAL ASSESSMENT

Do you currently use Schuylkill Transportation **fixed route** services at all? ___ Yes ___ No ___ Sometimes

Which route do you currently use? _____

When was the last time you independently used Schuylkill Trans. **fixed route** bus service? _____

Have you used Schuylkill Trans. **fixed route** bus service in the last year? ___ Yes ___ No ___ Sometimes

Which Schuylkill Trans. **fixed route** bus routes serve your neighborhood? _____

If you used the **fixed route bus service and stopped, please explain.** _____

What is the closest **fixed route** bus stop to your home? Please give the location (Ex. Corner of Fifth and Grant)

Can you get to this fixed bus route yourself? ___ Yes ___ No ___ Sometimes

- If no, why not? _____
- If you use Schuylkill Trans. **fixed route** bus service now, do you need the assistance of another person?
___ **Always** ___ **Never** ___ **Sometimes**
- If you ever need another person's assistance, what does the person do for you?

- What is it about riding a fixed route Schuylkill Transportation bus that is the most difficult for you? (Ex. The bus moves before I am seated) Please list as many things as you can think of:

- Can you ever cross the street by yourself? ___ Yes ___ No ___ Sometimes
- If yes, under what circumstances? _____

Please read the following statements and check those that best describe what you believe is your ability to use fixed route bus transportation by yourself. You may select more than one.

- I can use fixed bus route bus service frequently.
- I can use the bus sometimes, if conditions are right.
- I have difficulty understanding and remembering all of the things I would have to do to find my way to and from the bus.
- I believe I could learn to ride the bus, if someone taught me.
- I have difficulty or cannot climb stairs and can only board a bus if it has a lift.
- I have a visual disability that prevents me from ever getting to and from the bus, even with training.
- The severity of my disability can change from day to day. I can ride the bus only when I am feeling well.
- I can never use the bus myself.
- I can get to and from the bus stop if the distance is not too great, and the route is barrier free.
- There is no Schuylkill Transportation bus service in my area. I am not really sure if I can use the bus.
- My disability makes it impossible to walk to and from the bus, even in good weather.
- I do not want to ride the bus.
- I am not able to use the bus for other reasons: Please explain

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 ___ Sometimes

Describe when you need the assistance: _____

SCTA USE ONLY

APPROVED: Unconditional _____ Conditional _____ Temporary _____

Expiration of eligibility: _____ / _____ / _____

PCA: YES NO

Service denied: _____

By: _____

Signature

Date

Part 4: DEMOGRAPHIC INFORMATION

*The following information is not required for Shared Ride to sponsor 85% of your trip fare. This information is required by the Schuylkill County Office of Senior Services for reporting purposes.

***Ethnic Information:**

White ___ African American ___ Am. Indian/Alaskan Native ___
Asian American/Pacific Islander ___ Hispanic Origin ___ Other ___

***Yearly Income: (please circle one)**

1 Member Household – Above \$11,880 Below \$11,880
2 Member Household – Above \$16,040 Below \$16,040

Circle if: Refuse to Answer

***Other Information:**

Do you live alone? Yes ___ No ___
Are you frail or functionally disabled? Yes ___ No ___
Do you have adequate housing? Yes ___ No ___
Marital Status: Please check one of the following: Married ___ Single ___ Widowed ___ Divorced ___ Legally Separated ___
Do you understand English? Yes ___ No ___ Language _____
Are you a veteran? Yes ___ No ___
Veteran’s Dependent? Yes ___ No ___
Are you a US Citizen? Yes ___ No ___
Rural Yes ___ No ___
Homebound Yes ___ No ___
Are there any effects of a disability of which we need to be aware? _____

PART 5: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the P.W.D. program are not to be provided in place of any current transportation services that you already receive.

Do you now receive any transportation services or is 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 Aging
- ___ Medical Assistance Transportation Program
- ___ Americans with Disabilities Act Complementary Paratransit
- ___ Intellectual Development Disability (IDD) aka Mental Health/Mental Retardation
- ___ Office of Vocational Rehabilitation (OVR)
- ___ Group Home where you live
- ___ Aging Waiver
- ___ OTHER _____

Part 6: INCOME AND HOUSEHOLD RELATED DATA

If you are NOT registered for the Medical Assistance Transportation Program (MATP), you may qualify, and this program could pay all of the cost for your eligible trips to medical appointments.

Please complete the following:

_____ I am already registered with MATP.

_____ I already have Medical Assistance through the Department of Human Services and think I may qualify for MATP. I understand I must contact them directly to apply for transportation benefits. They can be reached at (570) 628-1425 or toll free at (888) 656-0700.

_____ I think that I may qualify for Medical Assistance through the Department of Human Services. I understand I can prescreen and apply for benefits directly by accessing www.compass.state.pa.us or by calling my local office at (570) 621-3000 or toll free at (877) 306-5439.

_____ I **DO NOT** think I qualify for Medical Assistance.

PART 7: RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION

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

I give my permission to STS to contact a healthcare or other professional for additional information to verify that I am a person with a disability or status on billing/other funding sources for services on my behalf and I understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by the Schuylkill Transportation System. 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 the form

Date

Name of the person who completed this form

Relationship

Telephone Number

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

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 application 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 to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political 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 **1-877-VOTESPA (1-877-868-3772)**.

(Signature)

(Date)