Ecolane ID: ________________________
STS Card #:________________________

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
2) Baptismal certificate
3) Birth certificate
4) PACE ID card
5) Resident Alien Card
6) Passport/naturalization papers
7) Pennsylvania ID card
8) Photo motor vehicle driver's license
9) Veteran's Universal Access ID 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: ________________________________
Date Registered: ____________________________
Details last reviewed: _________________________
Active: Yes or No: ____________________________
Reason Active: ______________________________
Status Date: ________________________________
End Date:

FOR OFFICE USE ONLY

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 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 ____

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

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