***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

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| 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**

Ecolane ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STS Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*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 \_\_\_\_\_\_

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| 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) Statement of age from U.S. Social Security  5) Resident Alien Card 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FOR OFFICE USE ONLY**

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**

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.”

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

YES\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_

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.

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| **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

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| **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 \_\_\_\_\_\_\_\_
* f 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 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **\*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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*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](http://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).**

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(Signature) (Date)