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 profession 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 Rural Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by the Wayne County Transportation System. If you have any questions about the form, please call *570-253-4280*.

Applicant Information (to be completed by applicant):

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

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, 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 lasts for 12 months or longer.)

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

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

_____ Mobility disability (please see question to the right)
_____ Vision disability
_____ Hearing disability
_____ Cognitive disability
_____ Mental disability
_____ Other — Please specify: _____

Please check all mobility aids that apply.

_____ Manual wheelchair _____ Crutches
_____ Power Wheelchair _____ Cane
_____ Motorized Scooter _____ Walker

_____
Signature of Professional Date

_____
Title Name of Agency or Organization

_____
Address Telephone

Please send completed form to:
Wayne County Transportation System
323 10th Street
Honesdale, PA 18431

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 the PwD project.

1. If you have 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 the transportation provider listed at the top of this form. 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 the transportation provider listed at the top of Page 1.

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

____Office of Vocational Rehabilitation (OVR)

____Social Security Insurance (SSI) and Disability Insurance (SSDI)

____Bureau of Blindness and Visual Services

____Center for Independent Living (CIL)

____Mental Health/Mental Retardation Program

____United Cerebral Palsy

_____Registered Physical/Occupational Therapist

_____Physician

_____Registered Nurse

_____PA Attendant Care Program

_____Community Services Program for Persons with Physical Disabilities

_____Other:_____

_____

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

Please fill out a certification of disability form available from _____. 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

_____Less than $10,000
_____$10,001-$15,000
_____$15,001-$20,000
_____$20,001-$25,000
_____$25,001-$30,000
_____$30,001-$35,000
_____$35,001-$40,000
_____$40,001-$45,000
_____$45,001-$50,000
_____$50,001-$55,000
_____$55,001-$60,000
_____$60,001+

Household Size

_____1
_____2
_____3
_____4
_____5
_____6
_____7
_____8+

PART 4: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the PwD project 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 complete all that apply from the following list.

____Senior Citizens Shared-Ride Transportation program
____Area Agency on Aging
____Medical Assistance Transportation Program
____Americans with Disabilities Act Complementary Paratransit
____Mental Health/Mental Retardation (MH/MR)
____Office of Vocational Rehabilitation (OVR)
____The training program I am in at _____
____The employment program I am in at _____
____The group home where I live
____Other (please explain)_____

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 County Assistance Office (CAO)

____I was referred to the CAO for MA 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 those 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 _____Crutches

_____Power wheelchair _____Cane

_____Motorized Scooter _____Walker

5. Do you require the services of a personal care attendant or escort when you travel? (A personal care attendant or escort is a person that you need to assist you during the trip or at your origin or destination)

_____Yes

_____No

_____Sometimes

Please describe when you need assistance:_____

_____

_____

6. Emergency Contact (Optional)

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 YOUR CERTIFIC ATION OF THE APPLICATION FORM

Release of Information

I give my permission to Wayne County Transportation System to contact a healthcare or other professional that I designate for additional information to verify that I am a person with a disability.

Yes_____ No_____

_____

(Your signature or that of 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 that of the person who completed this form) (Date)

_____

(Name of the person who completed this form) (Relationship) (Telephone Number)