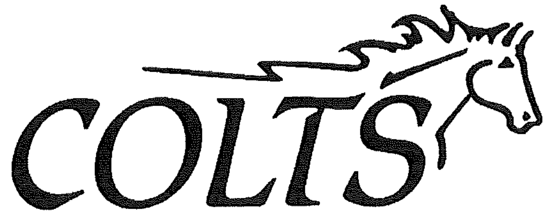

County of Lackawanna Transit System

COLTS Shared Ride
800 North South Road
Scranton, PA 18504
(570) 963-6795
Fax: (570) 207-5050

Enclosed you will find a SEATS application, PWD Rural Transportation for Persons with Disabilities application, Declination Form, and SEATS Information document.

SEATS Application;

Part A of the application has to be completed by the client and signed by the perspective SEATS client. If someone with assisting the perspective SEATS client with completing the application, that individual must be sign the document. **Part B** of the Application must be completed by a Medical Professional familiar with your disability. All **original** applications have to be returned to COLTS at the address below.

Declination Form;

Please sign the declination form, indicating if you are interested in registering to Vote, already registered to Vote, or not interested in Voting. Sign the bottom on the signature line. Singing this document has no bearing on your SEATS and/ PWD approval.

PWD Rural Transportation for Persons with Disabilities;

This application is for people with disabilities living in rural areas or people with disabilities traveling to rural areas. Parts 1, 2, 3, 4, and 5 can be completed by the client or someone assisting the client. Part 6 is a release for medical information, this section has to be signed by the client. Certification of Disability Form has to be completed by the client or someone assisting the client with the application, part 2 of the Certificate of Disability Form has to be completed by the agency or individual verifying the client's disability. A form of identification has to be returned with this application. All original documents have to be returned to COLTS Shared Ride.

If you have any questions please do not hesitate to contact our office at (570) 963-6795. Return the completed original application to above address.

Beth McDonald Zangardi
COLTS Shared Ride
800 North South Rd.
Scranton PA. 18504
570 963 6795 press 3

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?

____ 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 amount 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 you 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 1-800-522-VOTE (8683).

______________________________   ________________

Signature   Date

Eligibility and Registration Form
Rural Transportation for Persons with Disabilities (PwD) Project

◆ Reduced fare transportation service may be available to you if you are:
1. A person with a disability and
2. Age 18 - 64 and
3. Need accessible public transit in a participating county beyond ADA complementary paratransit services.

◆ If you would like to participate in this project, please complete this form and send it with a copy of one of the documents listed in Part 2 below to:

Lackawanna County Coordinated Transportation System
800 North South Road, Scranton, PA 18504

◆ Once your application is received and reviewed you will be notified of your eligibility to participate.

◆ If you have questions about this project, this form or need this form in an alternate format please call:
(570) 963-6795

Note: The information provided in this application regarding your disability will be used to determine your eligibility for reduced fare transportation services under the PwD project. Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and to provide you with the appropriate type of service. This information will be kept confidential and used only by professionals involved in evaluating your eligibility and in analyzing the pilot project for future recommendations. Please print clearly.

PART 1: GENERAL

Last Name: ______________________ First Name: ____________________ M.I.: __________

Address (Street & No.): ____

City: ______________________________ State: ____________ Zip Code: __________

Telephone: Home: __________________ Work: ________________ E-mail: ______________

County of Residence: ________________ Date of Birth: ____________

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?
____ Yes ____ No

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."

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
_____ $30,000-$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 the 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 CERTIFICATION OF THE APPLICATION FORM

Release of Information

I give my permission to ___________________________ to contact a health care 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

Eligibility and Registration Form — Supporting Information

Medical Assistance Transportation Program (MATP) Eligibility Information

Documentation of Disabilities

Three Categories of Disabilities – Attachment A

1) Mental impairment, including development disabilities
2) Physical impairment
3) Major life activities

Samples of Forms Used for Determining that a Person has a Disability

1) Attachment B: Washington County Transportation Program (WCTP) form to be completed by physician or agency
2) Attachment C: Office of Vocational Rehabilitation Comprehensive Medical Examination form
3) Attachment D: Attendant Care Service form
4) Attachment E: OSP/Independence Eligibility Review form
5) Attachment F: Certification of Disability Form: To be used if an applicant has no written documentation of his/her disability

Attachment G: Federal Poverty Income Guidelines

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,420 for each additional person.	
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

- **Learn more about:**
  - the Extra-Help program.
  - resource limits and co-payment benefits for the **full Low-Income Subsidy**: 2018 & 2019, and the
  - resource limits and benefits for the **partial Low-Income Subsidy**: 2018 & 2019

Attachment F

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 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 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 *Local Service Provider*. If you have any questions about the form, please call *(570) 963-6795*

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 application to: COLTS 800 North South Rd. Scranton, PA 18504