COLTS
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, SEATS Information documents and a Declination Form.

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 for, 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 approval.

If you have any difficulty in completing the application, or have any questions pertaining to the guidelines, please do not hesitate to contact our office at (570) 963-6795. Return the completed application to above address.

Thank you,

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

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www.coltsbus.com

Special Efforts Accessibility Transportation Service Program Application

PART A. To be completed by applicant or on behalf of the applicant. **Please Print**

Applicant _____ Male _____ Female

Last Name _____ First _____ MI _____

Residence Address: _____ APT# _____

City _____ State _____ Zip _____

Mailing Address (**if different**) _____

_____

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____ Ext._____ TTY ( ) _____

Date of Birth _____

Social Security Number _____

Emergency Contact (Required)

Name _____

Relationship _____

Address_____

Home Phone _____Work Phone _____ Ext _____

Cell Phone _____TTY_____

Application Information:

1. Are you a [ ] Current Passenger [ ] New Applicant

2. Which of the following condition(s), if any, prevent you from using the Fixed Route System?

Check all that apply:

[ ] None
[ ] Mental Illness
[ ] Deaf/Hard of Hearing
[ ] Physical [ ] Visual
[ ] Brain Injury [ ] Mental Retardation
[ ] Other_____

Explain in detail why this prevents you from using Fixed Route Buses

_____
_____
_____
_____

3. Are there any effects of your disability of which we need to be aware?

_____
_____
_____

4. Is your disability or health condition: [ ] Permanent [ ] Varies Daily

[ ] Temporary; expected to last until _____

5. Please indicate the primary mobility aids you use when traveling in the community:

[ ] Support Care
[ ] Long White Cane
[ ] Scooter
[ ] Hearing Aid
[ ] Other_____
[ ] Leg Braces
[ ] Alphabet Board
[ ] Powered Wheelchair
[ ] Prosthesis
[ ] Picture Board
[ ] Service Animal
[ ] Manual Wheelchair
[ ] Oxygen Tank
[ ] None
[ ] Crutches
[ ] Walker

Note: COLTS may not be able to accommodate you if your wheelchair or scooter is longer than 48" or wider than 30" or if your total weight with your wheelchair is more than 600 pounds. (ADA S 37.165)

6. Can you climb three steps with a handrail, without assistance?

[ ] Yes [ ] No [ ] Sometimes

7. Do you require a Personal Care Attendant (PCA) to help you travel? A PCA is a person specifically employed or designated to help with your daily living needs.

[ ] Yes [ ] No [ ] Sometimes

8. Have you applied and been denied the use of Para transit service with LCCTS before

[ ] Yes [ ] No If yes, how has your situation changed:

_____

_____

_____

_____

9. Have you ever used or been trained to use COLTS' fixed route buses?

[ ] Yes [ ] No

10. Check the items listed below that might help you ride COLTS' Fixed Route buses:

[ ] Help with trip planning
[ ] Help communicating
[ ] Someone to teach me
[ ] Wheelchair lift on bus
[ ] Bus stops closer to my house
[ ] Accessible route to bus stops

11. What is the closest bus route to your home?

[ ] Route _____ [ ] I do not know

12. Please answer the following questions:

a Can you travel 200 feet without the assistance of another person?
[ ] Yes [ ] No Sometimes_____

b Can you travel (¼ mile) without the assistance of another person?
[ ] Yes [ ] No Sometimes_____

c Can you travel (3/4 mile) without the assistance of another person?
[ ] Yes [ ] No Sometimes_____

d Can you climb three 12 inch steps without assistance?
[ ] Yes [ ] No Sometimes_____

e Can you stay outside without support for ten minutes?
[ ] Yes [ ] No Sometimes_____

Application must be signed at the bottom to be considered complete.

Person completing this form if other than Application (check one):

[ ] I certify that the information in this application is true and correct based upon the information given to me by the applicant.

[ ] I certify that information provided in this application is true and correct based upon my own knowledge of the applicant's health condition or disability or I have legal authority to complete this application.

Exceptions or Additions:

_____

_____

_____

_____

Print Name _____

Address _____

City _____ State_____ Zip_____

Day Time Phone number _____

Signature _____ Date _____

Relationship to Applicant _____

Agency Name _____

Applicant's Signature

I understand the purpose of this application is to determine if there are times when I cannot use COLTS Fixed Route buses and will require Para transit services. I understand the information on this application will be kept confidential and shared only with the professionals involved in evaluating my eligibility. I certify to the best of my knowledge, the information on this application is true and correct. I understand that providing false or misleading information could result in my eligibility status being terminated. I give permission to LCCTS staff to contact the professional who has filled out this application or given supplemental verification of my condition.

Applicant Signature_____ Date _____

Print Name_____

PART B

To be completed by a professional who is knowledgeable about the applicant's disability.

Dear Medical Professional:

Please assist us in our ADA transportation eligibility determination process by providing additional information about the applicant stated on the Medical/Professional Verification Form.

Please do not list a diagnosis as reason for need of Para transit services; we need to know how the limitation that the applicant has will limit their ability to ride a Fixed Route bus. The following is necessary for us to process the applicant's request.

- **Thorough detail of the applicant's functional limitation(s), and how they inhibit that person's ability to board, use, and disembark from a Fixed Route bus.**
- **Thorough detail of the applicant's cognitive limitation(s), and how they inhibit that person's ability to navigate using a Fixed Route Bus.**
- **Thorough detail of the applicant's physical limitation(s), and how they inhibit that person's ability to reach a bus stop or the destination from a bus stop.**

Under the Americans with Disabilities Act (ADA), if a person has the functional capability to use COLTS Fixed Route buses, that person is not eligible for Para transit services. Disability alone and distance to and from bus stop, by itself, do not qualify a person for LCCTS Para transit Service.

Many of COLTS Fixed Route buses offer lift-equipped buses that are available to persons who have difficulty or who are unable to use the steps to board and disembark the bus. Additionally, all of COLTS Fixed Route buses "kneel", which lowers the bus to the ground, making the first step from the curb easier to make.

If you think that the applicant could benefit from the services stated in the paragraph above, please make a note on the verification form so that their eligibility can be better determined and the proper services can be provided.

Thank you for your assistance. If you have any questions while completing the verification form, please contact our office at 963-6795.

SEATS ELIGIBILITY INFORMATION
MEDICAL/PROFESSIONAL VERIFICATION FORM

APPLICANT _____

To the Applicant: Sign below to allow the release of information from the professional who will be filling out this form:
I hereby request that information pertaining to my limitations that prevent me from using Fixed Route buses be released to LCCTS for further determination of my ADA Para transit eligibility.

X Signature_____Date_____

To the person completing this form:

This form must be filled out by a professional who is knowledgeable about the applicant's disability and limitations. Please check the appropriate boxes regarding the person completing the form.

[ ] Vocational Rehabilitation Counselor
[ ] Licensed Social Worker
[ ] Respiratory Therapist
[ ] Psychologist
[ ] Psychiatrist
[ ] Audiologist
[ ] Independent Living Specialist
[ ] O & M Instructor
[ ] Physician
[ ] Physical Therapist
[ ] Mental Health Counselor
[ ] Podiatrist
[ ] Optometrist
[ ] Other

1. Indicate nature of applicant's disability (check all that apply)

[ ] Alzheimer's
[ ] Autism
[ ] Cardiac
[ ] Cerebral Palsy
[ ] Cerebrovascular Accident
[ ] Deaf/Hard of Hearing
[ ] Dementia
[ ] Kidney Disease
[ ] Legally Blind
[ ] Neurological Handicap
[ ] Severely Visually Impaired
[ ] Arthritis: Specify extremity: _____
[ ] Impaired or assisted ambulation: Specify mobility aid: _____
[ ] Mental Illness
[ ] Mental Retardation (indicate one) [ ] Moderate [ ] Severe [ ] Profound
[ ] Pulmonary: Does applicant travel with Portable Oxygen Tank? [ ] Yes [ ] No
[ ] Seizures: Specify nature of: _____
[ ] Other _____

2. How does the applicant's disability limit their ability to use a lift equipped Fixed Route bus (must complete)

   _____

   _____

3. What is the expected duration of the applicant's disability?
   [ ] Permanent [ ] temporary: expected duration: _____

4. Does the applicant require a Personal Care Attendant (PCA) to assist with travel, a PCA is a person specifically employed or designated to help with daily living

[ ] Yes [ ] No [ ] Sometimes _____

5. Is there any other aspect of the disability that would assist LCCTS in making a determination on the applicant's ability to use Fixed Route buses? _____

_____

_____

6. If the applicant has a disability affecting mobility answer the following:

a. Assuming the length of a city block is 500 feet, how many blocks can this person walk without assistance? _____

b. Does this person use any mobility aids? [ ] Yes [ ] No
If yes, please list: _____

c. With use of mobility aid(s), how many blocks can he/she travel independently? _____

d. How many 7 inch steps can this person climb without assistance? _____

e. How many 10 inch steps can this person climb without assistance? _____

f. How long can this person wait for a bus at a bus stop [ ] 10 [ ] 15 [ ] 20 [ ] other [ ]

This section must be completed for application to be considered complete.

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

Signature _____ **Date** _____

Print Name _____

Professional Title _____

Clinic/Agency _____

Address _____

Phone _____

If Part B of this application is being completed separate from Part A, Please

Return to:

COLTS SEATS Program
800 North South Road
Scranton, PA 18504
(570) 963-6735
Fax: (570) 496-7726