



County of Lackawanna Transit System

800 North South Road  
Scranton, PA 18504  
(570) 963-6795  
Fax: (570) 207-5050  
[www.colts bus.com](http://www.colts bus.com)

In accordance with the regulations set forth by Pennsylvania Department of Transportation the following information is needed to complete the Lackawanna County Coordinated Transportation Systems application.

Most of the pertinent information has been completed on your application for you, through your initial contact with our office. Please **sign the application** in the appropriate highlighted area. A **copy of one** of the following "**proof of identification**" is necessary to complete the application: Birth Certificate, Baptismal Certificate, Veteran's Universal Access I.D. Card, Driver's License, Penn Dot Non Driver's License, Armed Forces Discharge, Statement of Age- Social Security Administration, Passport and Naturalization Papers, Pace I.D. Card and Resident Alien Card.

A copy of the Guidelines, are enclosed for your convenience. 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. **Send the completed application along with a copy of the appropriate I.D. to:**

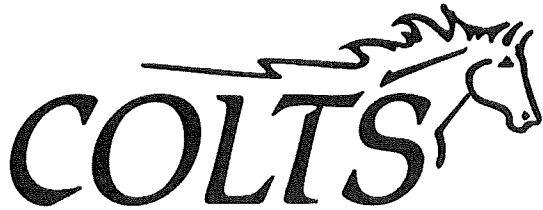
**COLTS  
800 North South Road  
Scranton, PA 18504**

**PLEASE CALL OUR OFFICE Five (5) DAYS AFTER MAILING APPLICATION  
TO MAKE SURE IT HAS BEEN RECEIVED**

**Thank you**

**Moscow Area Hours are between 11:00 a.m. and 1:00 p.m.**

**Carbondale Area Hours are between 11:00 a.m. the latest return is 1:00 p.m.**



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Fax: (570) 496-7726  
www.coltsbus.com

**SERVICE APPLICATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
\_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

Veteran: Yes  No  Lives Alone: Yes  No  Lives Rural: Yes  No

Marital Status \_\_\_\_\_ Social Security (last four digits only) \_\_\_\_\_

Special Needs \_\_\_\_\_  
**WHEELCHAIR CLIENT MUST HAVE A SEATBELT IN ORDER TO TRANSPORT**

Ambulatory \_\_\_\_\_ Wheelchair/Scooter/Jazzy \_\_\_\_\_

Medical Assistance Yes \_\_\_\_\_ No \_\_\_\_\_

If yes MA Provider # \_\_\_\_\_ Card Issue# \_\_\_\_\_

\_\_\_\_\_  
Client Signature

**COLTS use only:** Age Verification \_\_\_\_\_  
Client Category \_\_\_\_\_ Client # \_\_\_\_\_

Intake Worker \_\_\_\_\_ Reviewed by \_\_\_\_\_