County of Lackawanna Transportation System

Application for Paratransit Transportation Services
Persons with Disabilities (PWD) and ADA Program

The information provided in this application regarding your age, disability, and county of residence will be used to determine your eligibility for Shared Ride transportation services under the Rural Transportation for Persons with Disabilities and Senior 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 the appropriate referral service (ADA). This information is kept confidential and is used only by the professionals involved in evaluating your eligibility.

PLEASE PRINT

GENERAL / QUALIFYING QUESTIONS

First Name:	Middle Name:		Last Name:
Date of birth:	SSN:		Age:
Current address:			
City:	State:	Zip:	Email:
Home phone:	Cell phone:		County:
Emergency Contact:	Relationship:		Phone #:

AGE VERIFICATION

Please send a legible photo copy of one of the listed forms of proof of age along with this application. Please check which verification you are enclosing.

☐ Armed forces discharge/separation papers	☐ Pennsylvania ID card
☐ Passport/ naturalization papers	☐ Photo motor vehicle driver's license
☐ Baptismal certificate	☐ Birth certificate (*Maiden Name*)
☐ PACE ID Card	☐ Veteran's Universal Access ID Card
☐ Statement of age from U.S. Social Security Office	☐ Resident Alien Card

NEEDS ASSESSMENT

Do you have a disability according to the Americans w/ Disabilites Act (ADA)? If yes, please attach the ***Certification of Disability Form***

Do you have any mobility devices such as the following:

☐ Manual Wheelchair	☐ Crutches	☐ Oxygen	☐ Power Wheel Chair	☐ Guide Dog
☐ Motorized Scooter	☐ Cane	☐ Walker	Other:	

CURRENT TRAVEL

Do you use COLTS **Fixed Route** bus service? ☐ Yes ☐ No ☐ Sometimes

How do you currently get to your destination?

ENVIRONMENT AROUND YOUR RESIDENCE

How many steps are there at the entrance you use at your residence?

Can you get into a vehicle without the help of another person? ☐ Yes ☐ No

How would you describe the terrain where you live?

☐ Steep ☐ Hill ☐ Paved Lane ☐ Unpaved Lane

Are there sidewalks in your neighborhood? ☐ Yes ☐ No

MOBILITY FUNCTIONAL ASSESSMENT

For each question, check ***one*** answer. Your answers should be based on: how you feel most of the time; under normal circumstances; using your mobility equipment; and whether you can perform this activity independently.

Without the help of someone else, can you:

Walk up & down 3 steps if there are handrails on both sides?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Use the telephone to get information?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Cross the street, if there are curb cuts?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Ride up & down a wheelchair lift with handrails on both sides?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Find your way to the bus stop, if someone shows you the way?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Currently travel by yourself?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Wait 10 minutes in good weather outdoors without a place to sit?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Step on and off the curb from a sidewalk?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Travel up & down a gradual hill on the sidewalk, when the weather is good?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
Travel 3 level blocks, on the sidewalk, when the weather is good?	☐ Always	☐ Sometimes	☐ Never	☐ Unsure
If you are able to do the previous question, how long does it take you?	☐ <5 mins	☐ 5-10 mins	☐ >10	☐ Unsure
Have you ever gotten lost while traveling alone?	☐ yes		☐ no	

If the weather is good & there are no barriers in the way, what is the farthest you can walk/travel out-doors on a level sidewalk, using your mobility aid? (Please select the box which is closest to your answer)

☐ I cannot travel alone	☐ Less than 1 block	☐ 3 blocks	☐ 6 blocks
☐ Curb in front of house	☐ 9 blocks	☐ More than 9 blocks	Other:

PROFESSIONAL WRITTEN VERIFICATION OF DIABILITY

In order to be eligible based on a disability, the Certification of Disability (last page) must be completed by a qualified individual from one of the organizations listed below, that you are a person with a disability and you are ***in need*** of the ADA program.

Disability Insurance (SSDI)	United Cerebral Palsy	PA Attendant Care Program	Physician
Office of Vocational Rehabilitation (OVR)	Registered Nurse	Bureau of Blindness and Visual Services	
Community Services Program for Persons with Physical Disabilities		Center for Independent Living (CIL)	
Mental Health/Mental Retardation Program (MH-MR)	Registered Physical/Occupational Therapist		

Information contained in this application will be kept confidential and shared only with professionals involved in evaluating your eligibility and with appropriate COLTS personnel. COLTS staff may need to talk to the applicant to get more information.

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 understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by COLTS.

I give my permission to COLTS 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

By signing below, I hereby agree to report any changes in circumstances immediately to this Service Provider regarding my eligibility. I understand that documentation of all eligibility factors may be required to determine eligibility correctly. This affirmation statement covers this application and all attachments required for the determination of eligibility. This information will be held by only the Service Provider and its agents in the strictest confidence and will not be shared with any other agency, except the professionals from which we are receiving the information.

X _____

Your signature above (or name of the person who completed this form)

X _____

(Date) (Relationship) (Contact Number)

MAILING INSTRUCTIONS: PLEASE CHECK THE FOLLOWING BEFORE MAILING YOUR APPLICATION

- ☐ Include a copy of **ONE** form of proof of age
- ☐ Include a copy of any other important documents such as the ***Certification of Disability Form***
- ☐ **SIGN** the Release of information and Certification of Application section

PLEASE SEND COMPLETED FORM TO:

COLTS SEATS PROGRAM
County of Lackawanna Transit System
800 North South Road
Scranton, Pa. 18504
Ph: 570.963.6735
Fax: 570.496.7726

Certification of Disability Form

Transportation for Persons with Disabilities (PwD) and ADA

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 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 Transportation for Persons with Disabilities (PwD) Program and ADA, which administered by the Pennsylvania Department of Transportation.

Applicant Information **to be completed by applicant:**

Last name: First Name: Middle Initial:

Address (Street & No.):

City: State: Zip Code:

Telephone: Home: Work: Email:

Applicant or Applicant Representative signature Date

DEFINATION OF DISABILITY
Eligibility for this program is based on disability as defined by the Americans with Disabilities 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 impairment; or being regarded as having such am 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:**

How many blocks can this person walk unassisted? <1 block 1-2 blocks 2-3 blocks 6 blocks 9 blocks
(please circle one)

Is the applicant's disability permanent? Yes No
*permanent disability - lasts for 12 months or longer (please circle one)

If not, how long is it expected to last?

What is the nature of the applicant's disability? (Check all that apply from each column)

☐ Mobility disability	☐ Manual wheelchair	☐ Crutches
☐ Vision disability	☐ Power wheelchair	☐ Cane
☐ Hearing disability	☐ Motorized scooter	☐ Walker
☐ Cognitive disability	☐ Guide/Service Dog	☐ White Cane
☐ Mental disability	☐ Requires PA (nurse, health aid, etc.)	
☐ Other (please specify) -	☐ Requires Escort	

Signature of Professional Date

Title Name of Agency or Organization

Address Phone No.