



Application for Transportation Services
(MATP, Persons with Disabilities (PwD), ADA, Senior Shared Ride- 60-64 / 65+, Public Full Fare)

1. Transportation services may be available at a reduced rate, if you meet any of the following criteria:
 - You are currently on Medical Assistance through the Department of Human Services
 - You are a person with a disability between the ages of 18-64
 - You are a person who lives along a fixed route, but due to a disability cannot access it
 - You are aged 60 – 64 and live in Cambria County
 - You are aged 65+
2. If you would like to apply, please complete the application for transportation services and send it with any copies of qualifying documents to the address below.



1226 N. Center St.
Ebensburg Pa. 15931

3. Applications are processed in the order in which they are received.
4. For ADA customers, if we have not processed your application within 21 days of receipt, you will be given presumptive eligibility until we are able to make an eligibility determination.
5. Incomplete or missing information or documents will delay processing.
6. Once processed, a Mobility Planner will contact you to notify you of your eligibility.

If you have any questions or need this application in an alternate format, please call:

Mobility Planning at 1-800-252-3889, TDD: PA RELAY 711.

NOTE: 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 various programs including the Rural Transportation for Persons with Disabilities and Senior Shared 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. This information is kept confidential and is used only by the professionals involved in evaluating your eligibility.

Please Print

Ecolane ID: _____

How did you first learn about CamTran's paratransit system?	
☐ Hospital/Clinic Flyer	☐ Saw a Bus
☐ Friend/Family Member	☐ Senior Center
☐ Case Worker	☐ Advertisement: (Publication)
☐ Other: (Specify)	

GENERAL / QUALIFYING QUESTIONS					
First Name:		Middle Name:		Last Name:	
Date of birth:		Age:		Email:	
Current address:					
City:		State:		Zip code:	
Home Phone:		Cell Phone:		County:	
Emergency Contact:		Relationship:		Phone #:	

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY			
In order to be eligible based on a disability, the Certification of Disability must be completed by a qualified individual from one of the organizations listed below that you are a person with a disability and are eligible to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.			
Office of Vocational Rehabilitation (OVR)		Bureau of Blindness and Visual Services	
Disability Insurance (SSDI)		Registered Nurse	
United Cerebral Palsy		Physician	
PA Attendant Care Program		Registered Physical/Occupational Therapist	
Community Services Program for Persons with Physical Disabilities		Other _____	
Mental Health/Intellectual & Developmental Disability(MH-IDD)		Center for Independent Living (CIL)	

NEEDS ASSESSMENT		
What is your primary language?		
Do you have a medical assistance card? ☐ Yes ☐ No		
Do you have a disability according to the Americans w/ Disabilities Act (ADA)? If yes, attach the <i>Certification of Disability Form</i>		
Do you use any mobility devices such as...		
☐ Manual Wheel Chair	☐ Oxygen	☐ Cane
☐ Motorized Scooter	☐ Power Wheel Chair	☐ Walker
☐ Crutches	☐ Guide Dog	Other _____
Do you require the services of a personal care assistant or escort when you travel? (Someone that is needed to assist you during the trip or at the origin or destination) ☐ Yes ☐ No ☐ Sometimes		

AGE VERIFICATION: Please send a legible photocopy of one of the listed forms of proof of age along with this application
A Medicare card is not an acceptable proof of age. 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

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 CamTran.

I give my permission to CamTran to contact a healthcare or other professionals 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 for funding assistance. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services hearing. This affirmation statement covers this application and all attachments required for the determination of eligibility. I am authorizing that, if the Service Provider must verify information regarding my trips from medical providers to which I am traveling, in order to comply with the PA Department of Human Services regulations, you have my permission to do so. The 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 receive the information.

Your signature (or name person who completed this form) _____

Date: _____ Relationship: _____ Contact Number: _____

Please be sure to include the following with your application	☐ Proof of Age
	☐ Proof of Veteran Status
	☐ Certificate of Disability (Page 6)
	☐ Ensure your application is signed

CURRENT TRAVEL

Do you currently use CamTran's **fixed route** bus services? ☐ Yes ☐ No ☐ Sometimes

Does the weather affect your ability to use CamTran fixed route bus service? Yes ☐ No ☐ If yes, please explain:

List your most frequent destinations and how you get there now

Destination address where you go	How often do you go there?	How do you get there?
1.		
2.		

DUPLICATION OF TRANSPORTATION SERVICES

Do you currently receive any transportation services? ☐ Yes ☐ No

Are any of your transportation costs paid for by another program or organization? (Select from below all that apply)

☐ Senior Citizens Shared Ride Transportation Program	☐ Office of Vocational Rehabilitation (OVR)
☐ Medical Assistance Transportation Program	☐ Mental Health/Mental Rehabilitation (MH/IDD)
☐ Americans w/Disabilities Act Complementary Paratransit	☐ Area Agency on Aging
☐ Group Home (Where you live)	☐ Other _____

ENVIRONMENT AROUND YOUR RESIDENCE

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

Can you get to 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

DEMOGRAPHIC INFORMATION The following information is not required for Shared Ride to sponsor 85% of your trip fare. This information is required by the Offices for Aging, Inc. for reporting purposes.

Ethnic Information:

White ☐ African American ☐ Am Indian/Alaskan Native ☐ Asian American/Pacific Islander ☐ Hispanic Origin ☐

Do you live alone? ☐ Yes ☐ No

Do you have adequate housing? ☐ Yes ☐ No

VOTER REGISTRATION INFORMATION The following information is required for all persons applying for ADA Paratransit service.

If you are not registered to vote where you live now, would you like to apply to register to vote?

☐ Yes (if you respond yes to this question, a separate voter registration packet will be sent to you)

☐ No

☐ No, I am already registered to vote where I live now.

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 personnel at the office at which you submit this registration application form will remain confidential.

INCOME AND HOUSEHOLD RELATED DATA

If you are NOT registered for the Medical Assistance Transportation Program (MATP), you may qualify, and this program could pay all of the cost for your eligible trips to medical appointments

After reviewing the chart below I think that...

___ I'm already registered with MATP ___ I may qualify for MATP ___ I do not think I qualify for MATP

**UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
2021 POVERTY GUIDELINES**

Household Size (select one)		Annual Income (select one)		
___ 1	___ 2	___ less than \$14,820	___ \$14,821 - \$20,040	___ \$20,041 - \$25,260
___ 3	___ 4	___ \$25,261 - \$30,480	___ \$30,481 - \$35,700	___ \$35,701 - \$40,920
___ 5	___ 6	___ \$40,921 - \$46,140		___ \$46,141-\$51,360
___ 7	___ 8	For families/households with more than 8 persons, add \$5,220 for each additional person.		

MEDICAL ASSISTANCE INFORMATION (if applicable)

Access Card # _____ _ _

Recipient # _____ Card Issue # _____

Social Security Number # _____

Do you have a vehicle in the household? ___ Yes ___ No Who owns the vehicle?

Do you receive any of the following services? ___ Methadone ___ Dialysis ___ STAP-Camp Name
___ After School Services ___ Other _____

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 CamTran.

I give my permission to CamTran to contact a healthcare or other professionals 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 for funding assistance. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services hearing. This affirmation statement covers this application and all attachments required for the determination of eligibility. I am authorizing that, if the Service Provider must verify information regarding my trips from medical providers to which I am traveling; in order to comply with the PA Department of Human Services regulations, you have my permission to do so. The 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 receive the information.

Your signature (or name person who completed this form) _____

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

MOBILITY FUNCTIONAL ASSESSMENT

For each question below, 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 and down three 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 and 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 or down a gradual hill on the sidewalk, in good weather?	☐ 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 this, how long does it take you?	☐ < 5 min	☐ 5 – 10 min	☐ > 10	☐ Unsure
Have you ever gotten lost when traveling alone?	☐ Yes		☐ No	

If the weather is good and there are no barriers in the way, what is the farthest you can walk or travel outdoors on a level sidewalk, using your mobility aid? (Please select the box which most closely 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 _____

Have you ever received training to learn how to use the bus or travel around the community?	☐ Yes ☐ No
If yes, which agency or person provided the training?	When were you trained?
Did you successfully complete the training?	☐ Yes ☐ No If no, why not?
Was your training route specific?	☐ Yes ☐ No Which routes did you learn?
Would you like to participate in training to learn to ride the bus?	☐ Yes ☐ No

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY

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 is **eligible** to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.

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

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



Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

- I. THE PATIENT.** This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

Social Security Number or MA ID: _____

- II. AUTHORIZATION.** I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("Authorized Party") to use or disclose the following:

Any medical-related information needed to verify my receipt of medical services for the purpose described below

Hereinafter known as the "Medical Records."

- III. DISCLOSURE.** The Authorized Party has my authorization to disclose Medical Records to:

Name: Susquehanna Regional Transportation Authority (dba. rabbittransit)

Address: 901 N. Cameron Street, Harrisburg, Pa 17101

Phone: 1-800-632-9063 or Fax: 1-717-848-4853

E-Mail: info@rabbittransit.org

- IV. PURPOSE.** The reason for this authorization is:

To verify attendance to the appointment for medical services for which you received transportation through the Medical Assistance Transportation Program.

- V. TERMINATION.** This authorization will terminate:

Upon sending a written revocation to the authorized party.

- VI. ACKNOWLEDGMENT OF RIGHTS.**

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.



I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor.** Patient is _____ years old and considered a minor under state law.

☐ - **Being Incapacitated.** Patient is incapacitated due to: _____

☐ - **Other:** _____

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____



ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

- I. **SENSITIVE INFORMATION.** This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - I **consent** to have the above information released.

☐ - I **do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

- II. **HIV/AIDS.** This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - I **consent** to have the above information released.

☐ - I **do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

Certification of Disability Form
Reduced Fare Transportation Services
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 Transportation for Persons with Disabilities (PWD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by Cambria County Transportation Authority. If you have any questions about the form, please call 814-471-6601 or toll free at 1-800-252-3889.

Applicant Information **to be completed by applicant (A completar por el solicitante):**

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

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ E-mail: _____

Applicant or Applicant Representative signature

Date

Definition 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 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 (Hecho por profesional):**

How many blocks can this person walked unassisted? (Circle One) <1 block 1-2 blocks 2-3 blocks 6 blocks 9 blocks

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. Please check all mobility aids that apply.

_____ Mobility disability (please see question to the right)

_____ Vision disability

_____ Hearing disability

_____ Cognitive disability

_____ Mental disability

_____ Other — Please specify: _____

_____ Manual wheelchair _____ Crutches

_____ Power Wheelchair _____ Cane

_____ Motorized Scooter _____ Walker

_____ Guide/Service Dog _____ White Cane

_____ Personal Care Assistant (nurse, aide, etc.)

_____ Escort (MATP)

Signature of Professional

Date

Title

Name of Agency or Organization

Address

Telephone

Please send completed form to:
CamTran
1226 N. Center St, Ebensburg, Pa 15931