Dear PwD Program Applicant:

Thank you for requesting the enclosed People with Disabilities (PwD) Application from the Cambria County Transit Authority. Please complete the application with the proper documentation and return it the Cambria County Transit Authority, Attn: ADA/PwD Administrator - CamTran+, 1226 N. Center Street, Ebensburg, PA 15931.

This program is for the use of transportation for clients between the ages of 18-64 with disabilities that have no other transportation. This transportation is to be used as a last resort of transportation. Therefore, if you were eligible for County Assistance or Medical transportation through Community Action you would not be able to use the PwD service for those trips. However, if you had no transportation to go shopping or the bank then you would be able to use the PwD service.

Please note that your application for PwD may be processed more quickly if you can submit any medical diagnosis or other documentation to support your contention that you are disabled. Also, you may be contacted for additional information to verify your disabling condition.

Your information will be kept confidential. However, if you meet the guidelines for aide from the County Assistance Office, the Transit Authority will refer you to them, and you will be notified via letter that you have been referred. If you do not want this assistance, please notify us with your application. Please note that if the assistance office determines that you qualify for the Medical Assistance Transportation Program and decline this aide, medical trips will not be eligible through the PwD program.

Qualified rehabilitation professionals will review your application. These professionals are trained to determine if your disability qualifies you for the PwD service, along with the other qualifying information that is needed. These professionals will make an eligibility recommendation to the Transit Authority, with the Authority making the final recommendation.

After we receive your application and it is completed, we will have twenty (20) days to determine if you are eligible for PwD services or if you will be referred to other agencies for transportation. All information must be received within 60 days of the date of your application. Otherwise, your application will be discarded, and you will have to reapply.

You will be notified by mail of the determination. If you are determined to be eligible, you will receive specific information on how to use the PwD.

It is very important that you be on time at your point of origin and your return trip since others will be travelling with you. The bus driver is instructed to wait no longer than three (3) minutes. If you are going to be late or need to cancel your trip, let the dispatcher know.

The bus will stop at the curb in front of your house or the place where your trip originates. Wait at the curb or at the exact address, which you named when making your reservation. Wait where you can observe the bus' arrival and where the driver can see you. When boarding the bus, you must show the driver your ID card.

The bus driver cannot enter your home or assist in getting a wheelchair down steps. If you are in a wheelchair, the bus will be equipped with a lift to get the wheelchair into and out of the bus. The driver will assist you in entering the vehicle.

COST: The PwD Service is funded by the Pennsylvania Department of Transportation, Persons with Disabilities. It is only for persons with disabilities between the ages of 18-64. However, this funding only pays for a portion of the trip, and the passenger must pay a **$3.00** fare regardless of the origin of the trip.

If you have any question on trip destinations, fares, times, etc., the dispatchers will be able to help you. Please call (814) 471-6601, 1-800-252-3889 or TDD 1-800-601-8466.

Sincerely,

Funding Administration
Cambria County Transit Authority

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 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: Cambria County Transit Authority, 1226 N. Center St., Ebensburg, PA 15931

- 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 alternative format please call: 814-471-6601 or 1-800-252-3889

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 (No. and street): ____

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* are 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 a 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, please 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 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

____Bureau of Blindness & Visual Services

____Center of Independent Living (CIL)

____Community Services Program for Persons with

_____Registered Physical/Occupational Therapist

_____Physician

_____Registered Nurse

_____PA Attendant Care Program

_____Other:___________________________________

2. If you do not have written verification of a disability:

Please fill out a certification of disability form available from Hiram G. Andrews Center, 727 Goucher St., Johnstown, PA 15905. It provides verification of a disability according to the definition in the Americans with Disability Act (ADA). This form can be used to acquire the necessary information for verifying a disability from a qualified health professional. See **Attachment 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	Household Size
____Less than $10,000	_______1
____$10,001 - $15,000	_______2
____$15,001 - $20,000	_______3
____ $20,001 - $25,000	_______4
____ $25,001 - $30,000	_______5
____ $30,001 - $35,000	_______6
_____$35,001 - $40,000	_______7
_____$40,001 - $45,000	_______8 +
_____$45,001 - $50,000	
_____$50,001 - $55,000	
_____$55,001 - $60,000	
_____$60,001 +	

PART 4: AVOIDING DUPLIATION 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, 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.

_____I was referred to the County Assistance Office for Medical Assistance eligibility determination on

Date: ___________

Initials of staff person faxing the referral to the County Assistance Office______________

PART 5: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent? _____Yes _____ No
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)   _____Hearing disability

_____Vision disability   _____Cognitive disability

_____Other (please specify)_________________________   ______Mental disability

4. Please check all mobility aids that apply:

_____Manual Wheelchair _____Crutches

_____Power Wheelchair _____Cane

_____Motorized Scooter _____Walker

3. 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: ____

____

4. Emergency Contact (Optional)

Name: ____

Relationship: ____

Phone (home): ________________________________(work)_____________________________

5. 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 the Cambria County Transit Authority 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 person completing 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:

____

Person Who Completed this Form Relationship Telephone number

Medical Assistance Transportation Program – Eligibility Guidelines

In keeping with the maintenance of effort policy of the PwD project, transportation providers and their subcontractors, if appropriate, are required to refer Medical Assistance Transportation Program (MATP) eligible clients to that program for funding for their medical trips.

The County Assistance Office (CAO) provides individuals who are eligible for MA with an ACCESS Card. Eligibility for MA and MATP is confirmed through the Department of Public Welfare's computerized Eligibility Verification System or EVS. All MATP providers are required to verify a client's MATP eligibility through EVS, which can be accessed by telephone, a pint of sale device, or through an EVS provided computer disk, MATP eligibility verification information must be recorded.

If a transit provider is not also the MATP coordinator, then the transit provider must require the MATP coordinator to check on a client's eligibility status through EVS or the client must be referred to the CAO for an assessment of MA Eligibility. The transit provider must notify the client of his or her referral to the CAO prior to making the actual referral.

Clients of the PwD project, whose incomes indicate a possible eligibility for MA, must be referred to the CAO for a determination of eligibility for MA and other programs. A client who is determined eligible for MA is also eligible for the MATP. PwD providers must then refer them to the MATP for funding of their medical trips. Clients must also receive notification of the CAO referral in advance.

Documentation of Disabilities

The transit provider must obtain documentation of the disability as identified by the applicant. Transportation authorities that have established ADA eligibility determination procedures can use these procedures as a base for the pilot project's disability eligibility determination.

All agencies should accept the eligibility determinations and documentation that have been prepared by organizations and programs that interact with the disability community. Examples of these agencies and programs include the following:

- Social Security Administration's SSI and SSDI eligibility determinations and supporting documentation, such as a SSDI Card.

- Cambria County Transportation Program's (WCTP) disability determination form to be completed by a physician or agency. A copy of the form is provided as **Attachment B**.

- Office of Vocational Rehabilitation's (OVR)_ establishment of a mental or physical disability through its Comprehensive Medical Examination. A copy of this form is **Attachment C.**

- Attendant Care Program qualifying disability: any medically determinable physical impairment that can be expected to last for a continuous period of not less than 12 months. The standard form used by this program is included as **Attachment D**.

- A qualifying disability through the Community Services Program for Persons with a Physical Disability. A medically determinable condition, excluding primary diagnoses of mental retardation or mental illness, expected to continue indefinitely: and resulting in at least three of the following six substantial functional limitations: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. This program's OSP/independence Eligibility Review form is **Attachment E**

- The Certification of Disability Form that has been developed for the pilot project. This form, which is **Attachment F**, provides verification that an applicant has a disability according to the definition in the Americans with Disabilities Act (ADA). If there is no organization available to provide the disability documentation, then the transit provider should use this form to acquire the necessary information for determining eligibility from a qualified medical provider.

  The transit provider may also permit another agency to complete the Registration and Eligibility Form. This is acceptable if all of the necessary eligibility documentation is provided to the transit provider with the application.

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
6. **Attachment G:** Federal Poverty Income Guidelines

ATTACHMENT A

Three Categories of Disabilities

Rural Transportation for Persons with Disabilities (PwD) Program

Disabilities are described in the following three categories:

1) Mental Impairment, including development disabilities

   a. Is attributable to a mental or physical impairments.

   b. Is likely to continue indefinitely.

   c. Results in substantial functional limitations in any of the following areas of major life activities: self-direction, learning, mobility, economic self-sufficiency, self-care, capacity for independent living and receptive and expressive language.

   d. Causes the substantial diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, attention impairment, cognition impairment, language impairment, memory impairment, conduct disorder, or motor disorder.

2) Physical impairment

   a. Persons having a physical condition resulting from injury, disease, or congenital deficiency which significantly interferes with or limits one or more major life activities and affects one or more of the following body systems: anatomical, musculoskeletal, neurological, respiratory including speech organs, cardiovascular, reproductive, digestive, Genito-urinary, hemic and lymphatic, skin and endocrine.

   b. The term physical impairment includes but is not limited to such contagious or non-contagious diseases and conditions as orthopedic, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV Disease and tuberculosis.

3) Major life activities

   a. Activities relating to the performance of self-care and engaging in leisure or play activities. Self-care includes grooming, mobility, object manipulation, and ambulation.

   b. Activities relating to the ability to walk, see, hear, breathe or communicate.

   c. Activities relating to moving about in one’s community for purposes that include accessing and participating in vocational, educational, recreational, and social activities in the community with other members of the community.

Attachment C

Commonwealth of Pennsylvania
Department of Labor and Industry

OVR D.O. Stamp

____
Social Security Number

____
Client Number

____
Date of Birth

Comprehensive Medical Examination

Section I – Counselor's Summary

____ _____ S__M__W__D__Sep__
Last Name First Middle Sex Martial Status

____
Address: Street and Number City State Zip Code

Usual Occupation:___________________________Description & Date of Last Job:________________________

____

Past Hospitalization:____

Client's Statement of Disability:____

____

Client's State of Treatment Given: ____

____

____
Counselor's Signature Date

Section II – Physician's Report

Past Medical History:____

____

History of Present Illness or Disability:____

____

____

____

Section III – Physical Examination

Blood Pressure________________ Pulse_________ Respiration __________ Height ________ Weight ________
Vision (distant) R: 20/_____ L: 20/______ with glasses: R: 20/_______ L: 20/_______
Hearing: R: 15/_____ L: 15/______

	Normal	Describe Abnormality
1. Eyes (discharge, strabismus, pterygium, pyrosis, fundi, cataract, etc.)		
2. Ears (evidence of deafness, middle ear or mastoid disease, drums: absent, perforated, dull, retracted, discharge)		
3. Nose (obstruction, evidence of chronic sinus, infection polyp)		
4. Throat (tonsils: enlarged, removed)		
5. Mouth (missing teeth, pyorrhea, caries, abnormal tongue or palate)		
6.Neck (thyroid, enlargement, nodules, masses)		
7.Breasts (abnormal discharge, nodules, tenderness)		
8.Lungs (conformation, respiratory movement, breath sounds, rales, dullness)		
9.Heart (enlargement, thrills, murmurs, rhythm, dyspnea, cyanosis, edema)		
10.Arteries (peripheral pulsations)		
11.Veins (varicose: location, severity)		
12. Abdomen (scars, asses, palpable liver or spleen, tenderness)		
13. Hernia (size, type, severity)		
14. Genitalia – Male (discharge, varicose		
15. Gynecological (describe significant abnormal conditions, severity and extent)		
16. Ano-Rectal (severity & extent of hemorrhoids, prolapse, fissures, fistula)		
17.Nervous System (gait, reflexes, sensation, paralysis, speech, etc.)		
18.Physhiatric (mood, abnormal behavior, etc.)		
19. Skin (lesions, scars, abnormalities – extent and severity)		
20. Orthopedic (congenital or acquired impairments, feet, back amputation, etc.)		

Section IV – Laboratory

Urinalysis: S.G. ______________ Albumen _________________ Sugar ___________________
Serology Indicated: Yes__________ No___________

Section V – Clinical Impressions (Diagnosis): (what are the limitations of activities?)

____
____

(A) If disability prevents employment in the labor market, will medical and or surgical treatment increase patient's chance for both gainful activities, including homemaking duties? Yes________ No________
(B) Indicate additional laboratory procedures and/or specially examinations you would recommend
____

____
Physician's Signature Date Print Name

____
Street Address City State Zip Code

Send copy of specialty examinations? Yes_____ No _____

ATTACHMENT D

APPLICATION FOR ATTENDANT CARE SERVICES

Consumer Information			
Name of Consumer (Last, First, Middle)			**Date**
Address (Street, Apt No. City, State		**Zip Code**	**County**
Phone #	**Birth Date**	**Social Security #**	
Disabilities			**Date of Onset**

___Yes __No Do you expect your physical disability(s) to last for a continuous period of not less than 12 months?

___Yes ___No Are you capable of selecting, supervising, and if needed, firing an attendant?

___Yes ___No Are you capable of managing or directing others to manage your own financial and legal affairs?

___Yes ___No Do you require assistance to complete functions of daily living, self-care, and mobility in the following:

☐ Bowel, Bladder of other bodily functions ☐ Grooming ☐ Transfers ☐ Meal Preparation ☐ Ambulation
☐ dressing ☐Consumption of Food ☐ Bathing ☐ None of the above
☐ Other:

☐ Yes ☐ No Are you currently receiving attendant care or other in-home services from another agency?
If yes, specify:

Explain you need and reason for applying for attendant care services:

Provider Information	
Name of Provider Agency	**M.A. ID**
Name of Provide Representative Completing this Form	**Telephone No.**

☐ Yes ☐No Is the consumer’s name listed on a valid PA Access Card?

ATTACHMENT F

Certification of Disability Form
Reduce 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 1-800-252-3889.

Applicant information (to be completed by applicant):

Last Name:________________________________First Name:_____________________M.I.:_________

Address (Street & No.):____

City:____State:__________ Zip Code:______________

Telephone: Home: _____________________________ Work: ______________________________

Email:____

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 the eligibility information) **Is the application disability permanent (to last beyond 12 months)? _______Yes ______ No**

If no, how long is the 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:____

lease 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:____Phone #:___________________________________

Please send completed form to: Cambria County Transit Authority, 1225 N. Center St, Ebensburg, PA 15931

ATTACHMENT G

250% of the 2005 Federal Poverty Income Guideline

FAMILY SIZE	MONTHLY LIMIT	ANNUAL LIMIT
1	**$1,994**	**$23,925**
2	**$2,673**	**$32,075**
3	**$3,352**	**$40,225**
4	**$4031**	**$48,375**
5	**$4,711**	**$56,525**
6	**$5,390**	**$64,675**