



**Eligibility and Registration Form  
Rural Transportation for Persons with Disabilities  
(PWD) Program**

- ⊕ Reduced fare transportation may be available to you if you are:
  1. A person with a disability and
  2. you are between the ages of 18 and 64 and
  3. you need transportation in locations more than  $\frac{3}{4}$  of a mile off the MCTA fixed route.
  
- ⊕ If you would like to apply for this program, please complete this form and return it with written verification of disability to:

*Monroe County Transportation Authority  
"Pocono Pony"  
ATTN: PWD Program  
PO Box 339  
Scotrun, PA 18355*

- ⊕ Once your application is received, it will be reviewed and you will be notified of your eligibility status within 15 business days.
  
- ⊕ If you have questions about the program or need this form in alternate format, **(large print)** please call: **570-839-6282**.  
\*Este formulario también puede ser solicitado en Español.

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 program. 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 assessing the program for future recommendations. **(Please print clearly.)**

**Part 1: General Information**

Date of Application: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ APT # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone # Home: \_\_\_\_\_ Work: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Please provide physical address if different from mailing address:

\_\_\_\_\_

Please provide clear instructions to your home (mandatory)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?      Yes \_\_\_\_\_      No \_\_\_\_\_

**Definition of Disability under the Americans with Disability Act.**

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.”

**Part 2: Written Verification of a disability**

**Attached written verification of disability is required.**

You may already have written verification that you are a person with a disability from a physician or other service organization. If so, please include a copy with your PWD application.

If you do not have a form of written verification, you will need to get written verification of your disability from ONE of the organizations or persons listed below.

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

**Part 3: Information to Serve you Better**

1. Is your disability permanent?    Yes \_\_\_\_\_    No \_\_\_\_\_  
Standard definition of a permanent disability is one that lasts 12 months or longer.

2. If **NO**, how long is it expected to last? \_\_\_\_\_

3. What is the nature of your disability? (Check those that apply)

\_\_\_\_\_ *Mobility Disability*

\_\_\_\_\_ *Vision Disability*

\_\_\_\_\_ *Hearing Disability*

\_\_\_\_\_ *Cognitive Disability*

\_\_\_\_\_ *Mental Disability*

\_\_\_\_\_ *Other* (Please Specify): \_\_\_\_\_

4. Please check all mobility aids that you currently use

\_\_\_\_\_ *Manual Wheelchair*

\_\_\_\_\_ *Crutches*

\_\_\_\_\_ *Other*

\_\_\_\_\_ *Power Wheelchair*

\_\_\_\_\_ *Cane*

\_\_\_\_\_ *Motorized Scooter*

\_\_\_\_\_ *Walker*

5. Do you require services from a personal care attendant or escort when you travel?

Yes \_\_\_\_\_    No \_\_\_\_\_

(An escort is necessary when a person is **NOT** able to board and disembark independently and/or **NEEDS** assistance during the course of the trip.)

Describe your need for assistance if applicable: \_\_\_\_\_

\_\_\_\_\_

**Part 4: Avoiding Duplication of Transportation Services**

Transportation services provided under the PWD program are NOT to be provided in place of any current transportation services that you already receive.

To help us serve you better, do you currently receive transportation services or any other services from the providers listed below? Yes \_\_\_\_\_ No \_\_\_\_\_  
(Please check all that apply.)

- \_\_\_\_\_ Senior Citizens Shared-Ride Transportation Program
- \_\_\_\_\_ Area Agency on the Aging
- \_\_\_\_\_ Medical Assistance Transportation Program
- \_\_\_\_\_ Americans with Disability Act. Paratransit
- \_\_\_\_\_ Mental Health/Mental Retardation (MH/MR)
- \_\_\_\_\_ Office of Vocational Rehabilitation (OVR)
- \_\_\_\_\_ Group Home where you live
- \_\_\_\_\_ Other (Please Specify)\_\_\_\_\_

**Part 5: Income and Household Related Data**

Passenger income related data is being collected to help develop demographics on our riders. It may also help to determine eligibility for other funded transportation programs. **Please note, Income will NOT be used to determine eligibility for the PWD.**

Please check the appropriate space in each column:

<u>Annual Income</u>		<u>Household Size</u>
_____ Less than \$10,000	_____ \$45,001-\$50,000	_____ 1
_____ \$15,001-\$20,000	_____ \$50,001-\$55,000	_____ 2
_____ \$20,001-\$25,000	_____ \$55,001-\$60,000	_____ 3
_____ \$25,001-\$30,000	_____ \$60,000+	_____ 4
_____ \$30,001-\$35,000		_____ 5
_____ \$35,001-\$40,000		_____ 6
_____ \$40,001-\$45,000		_____ 7
		_____ 8+

**Part 6: Release of Information and Your Certification of Application**

A) I give my permission to Monroe County Transit Authority; “Pocono Pony” to contact either the physician or other service organization, I selected in Part 2, for verification of my disability should any additional information be needed.

Yes \_\_\_\_\_ No \_\_\_\_\_

X \_\_\_\_\_

Your Signature (or signature of your representative)

\_\_\_\_\_ Date

B) I give my permission to Monroe County Transit Authority; “Pocono Pony” to contact the Monroe County Assistance Office or other organizations to determine eligibility for other transportation program funding.

Yes \_\_\_\_\_ No \_\_\_\_\_

X \_\_\_\_\_

Your Signature (or signature of your representative)

\_\_\_\_\_ Date

C) I understand that the purpose of this application is to determine if I am eligible to participate in the PWD program. I certify that the information contained in this application is correct and truthful to the best of my knowledge.

X \_\_\_\_\_

Your Signature (or signature of your representative)

\_\_\_\_\_ Date

\_\_\_\_\_  
Please print name of person who completed this form (self or representative) Date