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 ¾ 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 the WRITTEN VERIFICATION OF DISABILITY FORM (attached) 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:_____

Phone #_____ Cell or Work #_____

Date of Birth:_____ Social Security #:_____

Emergency Contact:_____Emergency Phone #:_____

Please provide physical address if different from mailing address:

_____

Include directions to your home: Start from a main road near home. MUST INCLUDE: Names of Roads, which side of the street is home, color of house and any landmarks.

_____

_____

_____

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: <u>Written Verification of a disability</u>

Attached is the written verification of disability form and it must be completed and attached for registration.

1. Please choose <u>one</u> of the following, or your choice of qualified health professional/health care organizations to complete the ATTACHED **WRITTEN VERIFICATION OF DISABILITY FORM.**

_____ Office of Vocational Rehabilitation (OVR)
_____ Current YEAR statement from Social Security Disability Insurance, (SSI) or (SSD)
(Must be coded "HA" meaning disabled at top right of SS form)
_____ 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_____

2. **CHOOSE ONE AND ATTACH ONE COPY LISTED BELOW FROM ACCEPTED PROOF OF AGE DOCUMENTS:**

___ Driver's License/State Photo ID
___ Birth Certificate (MUST HAVE SEAL)
___ Passport/Naturalization Papers_
___ Armed Forces Discharge Papers
___ Veteran's ID Card (Must Show DOB on Card)
___ Resident Alien Card

NO OTHER FORM OF PROOF OF AGE ID WILL BE ACCEPTED

Part 3: <u>Information to Serve you Better</u>

1. Is your disability permanent? Yes_____ No_____
   Standard definition of a permanent disability is one that lasts 12 months or longer.

2. If ***NO***, please enter (Start date & end date)_____

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_____

6. **If answer is yes to #5, an escort application and physician's verification forms are Obtained by contacting MCTA, Ask for SHARON, and have the 2 forms completed by a qualified health Professional.**
   (An escort is necessary when a person is **NOT** able to board and disembark independently and/ or **NEEDS** assistance during 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:

Annual Income		**Household Size**
_____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

Monroe County Transit Authority
POCONO PONY

Physicians Verification

In order to permit the MCTA to determine whether a passenger is eligible for Paratransit service by reason of the passenger's medical or mental condition, disability, or disabilities or where the passenger has medical or mental conditions which make it otherwise difficult for the passenger to walk to a bus stop, the MCTA requests that you (the passenger's physician) provide to the MCTA information regarding the Passenger/Applicant's ability to use the MCTA Fixed Route bus service.

Passenger/Applicant's Name: _____

Passenger/Applicant's Address: _____

Passenger/Applicant's Telephone #: _____

- Does the above named Passenger/Applicant have the physical and mental ability to safely ride the MCTA Fixed Route bus system? _____ Yes _____ No
  If no, please state why? _____
- What are the physical or mental limitations that prevent Passenger/Applicant from riding the MCTA Fixed Route bus system?
  _____
- Is the Passenger/Applicant's disability or medical or mental condition anticipated to persist longer than 12 consecutive months? _____ Yes _____ No
  If no, please give date for expected duration of disability? _____
- In your opinion, what is the distance the Passenger/Applicant may walk? _____
- Does this Passenger/Applicant require an escort to travel on the MCTA bus system? _____ Yes _____ No
  If yes, Please state how this escort assists this person _____
  _____

The undersigned Passenger/Applicant hereby consents and hereby authorizes the undersigned Physician to provide the foregoing medical information concerning the Passenger/Applicant to the MCTA.

Passenger/Applicant's Signature:_____Date:_____

Physician's Signature: _____

Physician's Printed Name: _____
(Physicians Stamp is acceptable)

Physician's Address: _____

Physician's Telephone #_____ Date: _____

Physician's PA License #_____

Please return by fax to 570-839-8205

** For Medical Assistance Clients**

MATP requires MCTA to provide the least expensive/most appropriate mode of service to an individual. The information you provide will allow us to better evaluate the Passenger/Applicant's request and provide the most appropriate level of service. Thank you for your cooperation.

FOR INTERNAL USE ONLY

Funding source:	Reviewer Signature and Date: