



COMMUNITY TRANSIT

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 a 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:

**Community Transit of Delaware County, Inc.
206 Eddystone Avenue
Eddystone, PA 19022-1514**

- ◆ 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 alternate format please call:
610-490-3977 or 610-490-3990 (TTY)

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 (Street & No.): _____

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* means 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 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, 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 top of page 1.

Please check the organization or individual whose written verification you are submitting with your application form.

- | | |
|--|--|
| <input type="checkbox"/> Office of Vocational Rehabilitation (OVR) | <input type="checkbox"/> Registered Physical/Occupational Therapist |
| <input type="checkbox"/> Social Security Insurance (SSI) and Disability Insurance (SSDI) | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Bureau of Blindness and Visual Services | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Center for Independent Living (CIL) | <input type="checkbox"/> PA Attendant Care Program |
| <input type="checkbox"/> Mental Health/Mental Retardation Program | <input type="checkbox"/> Community Services Program for Persons with Physical Disabilities |
| <input type="checkbox"/> United Cerebral Palsy | <input type="checkbox"/> Other: _____ |

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

Please fill out a certification of disability form available from (Attachment A). It provides verification of a disability according to the definition in the Americans with Disabilities Act. This form can be used to acquire the necessary information for verifying a disability from a qualified health professional. See Exhibit 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
<input type="checkbox"/> Less than \$10,000	<input type="checkbox"/> 1
<input type="checkbox"/> \$10,001-\$15,000	<input type="checkbox"/> 2
<input type="checkbox"/> \$15,001-\$20,000	<input type="checkbox"/> 3
<input type="checkbox"/> \$20,001-\$25,000	<input type="checkbox"/> 4
<input type="checkbox"/> \$25,001-\$30,000	<input type="checkbox"/> 5
<input type="checkbox"/> \$30,000-\$35,000	<input type="checkbox"/> 6
<input type="checkbox"/> \$35,001-\$40,000	<input type="checkbox"/> 7
<input type="checkbox"/> \$40,001-\$45,000	<input type="checkbox"/> 8 +
<input type="checkbox"/> \$45,001-\$50,000	
<input type="checkbox"/> \$50,001-\$55,000	
<input type="checkbox"/> \$55,001-\$60,000	
<input type="checkbox"/> \$60,001+	

PART 4: AVOIDING DUPLICATION 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 (MA), 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 (CAO)
- I was referred to the CAO for MA eligibility determination on (date): _____
- Initials of staff person faxing the referral to the CAO _____

PART 5: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent? Yes No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.)
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)
 - Vision disability
 - Hearing disability
 - Cognitive disability
 - Mental disability
 - Other — Please specify: _____
4. Please check all mobility aids that apply.
 - Manual wheelchair Crutches
 - Power Wheelchair Cane
 - Motorized Scooter Walker

5. 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: _____

6. Emergency Contact:

Name: _____
Relationship: _____
Phone (Home): _____ (Work): _____

7. 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 _____ 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 That of the Person Who Completed This 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

Name of the person who completed this form Relationship Telephone number

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: Office of Vocational Rehabilitation Comprehensive Medical Examination form
- 2) Attachment C: Attendant Care Service form
- 3) Attachment D: OSP/Independence Eligibility Review form
- 4) Attachment E: Certification of Disability Form: To be used if an applicant has no written documentation of his/her disability

Attachment G: Federal Poverty Income Guidelines

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 point 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 request 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/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.
- Washington 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. 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.

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 impairment or a combination of mental and 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, visual, speech and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, 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 B

**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

Marital Status

Address: Street and Number

City

State

Zip Code

Usual Occupation

Description and Date of Last Job

Past Hospitalization

Client's Statement of Disability

Client's Statement of Treatment Given

Counselor's Signature

Date

Section II — Physician's Report

Past Medial 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, pyosis, 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, dyspnoea, cyanosis, edema)		
10. ARTERIES (peripheral pulsations)		
11. VEINS (varicose: location, severity)		
12. ABDOMEN (scars, masses, palpable liver or spleen, tenderness)		
13. HERNIA (size, type, severity)		
14. GENITALIA—MALE (discharge, varicocele, hydrocele, prostate)		
15. GYNECOLOGICAL (describe significant abnormal condition, severity and extent)		
16. ANO-RECTAL (severity and extent of hemorrhoids, prolapse, fissures, fistula, etc.)		
17. NERVOUS SYSTEM (gait reflexes, sensation, paralysis, speech, etc.)		
18. PSYCHIATRIC (mood, abnormal behavior, etc.)		
19. SKIN (lesions, scars, abnormalities — extent and severity)		
20. ORTHOEDIC (congenital or acquired impairments, feet, back, amputations, etc.)		

Section IV — Laboratory

Urinalysis: S.G. _____ Albumen _____ Sugar _____

Serology Indicated: Yes. _____ No _____

Section V — Clinical Impressions (Diagnosis): (What are the limitation of activities?)

(A) If disability prevents employment in the labor market, will medical and or surgical treatment increase patient's chance for other gainful activities, including homemaking duties? Yes _____ No _____

(B) Indicate additional laboratory procedures and/or specialty examinations you would recommend.

Physician's Signature

Date

Physician (Print Name)

Street Address:

Send copy of specialty examinations? Yes _____ No _____

City, State, Zip

Attachment C**Application for Attendant Care Services****Consumer Information**

Name of Consumer (Last, First, Middle)		Date	
Address (Street, Apt. No., City, State)		Zip Code	County
Telephone No.	Birth Date	Sex	Social Security Number

Disabilities	Date of Onset
	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 other 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:
(If yes, check all that apply)

Bowel, bladder or 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 your need and reason for applying for attendant care services.

Provider Information

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

Yes No Is the consumer's name listed on a valid PA Access card?

If yes, show PA Access card (information recipient number and card issue number) and enter zero (0) under weekly fee

Recipient Number	Card Issue Number
------------------	-------------------

Family Composition

Name Last, First, M.I. (include applicant)	Relationship	Source of Income	Monthly Gross Income
Total Family Size »		Total Monthly Income »	
		Less Medical Expense Deduction »	
		Adjusted Monthly Income »	
		Weekly Fee »	

Medical Expense Deductions

Monthly Total: \$ _____

Affirmation of Information

I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete. I agree to report any changes in circumstances immediately to this service provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes. I understand that I have a right to request a department of public welfare fair hearing. This affirmation statement covers both sides of this form and all attachments required for the determination of eligibility under the attendant care program.

Signature of consumer

Attachment D**OSP/OBRA Waiver Eligibility Review**

		Date
Consumer's Name		Social Security Number
Age	County of Residence	Referral Source
Primary Dx		Secondary Dx

A. General Exceptions

	Yes	No
1. Is the consumer under the age of 18?		
2. Is the consumer comatose?		
3. Is the consumer ventilator dependent?		
4. Is the consumer terminally ill?		
5. Does the consumer function at the brain stem level?		
6. Does the consumer have a diagnosis of Alzheimer's or any other dementia?		
7. Do service costs exceed current cost of nursing facility placement?		

B. Mental Retardation Exceptions

	Yes	No
1. Does the consumer have a past or current primary Dx of mental retardation?		
2. Does the consumer have a documented IQ below 70?		
3. Does the consumer receive services through an MR waiver?		
4. Does the consumer have severe deficits in adaptive behavior?		

C. Mental Illness Exceptions

	Yes	No
1. Does the consumer have an official CURRENT Dx of a major mental disorder?		
2. Has the consumer been hospitalized more than once within the past two years for psychiatric treatment more intensive than outpatient psychiatric care?		
3. Within the past two years, has the consumer experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in residential treatment, or which resulted in intervention by housing or law enforcement officials?		
4. Is there presenting evidence of suicidal or homicidal ideation?		
5. Is there presenting evidence of hallucinations or delusions?		

D. Exceptions

If any of the above are checked "yes," the consumer is not eligible unless justification can be provided in the comments section below:

E. Three Substantial Functional Limitations

Please check either "yes" or "no" to indicate whether the consumer has a substantial functional limitation in each of the six areas listed below. In addition, for those areas checked "yes," please provide comments to substantiate the claim.

	Yes	No
1. Self Care: A person who has a condition, which requires that person to need significant assistance to look after personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance at least one-half of the time of all activities normally required for self-care.		

Comments

	Yes	No
2. Communication: A person who has a condition, which prevents that person from effectively communicating with another person without the aid of a third person, a person with special skills, or with a mechanical device, or a long-term condition which prevents him or her from articulating thoughts.		

Comments

	Yes	No
3. Learning: A person who has a condition, which seriously interferes with cognition, visual, or aural communication, or use of hand to the extent that special intervention or special programs are required to aid that person in learning.		

Comments

	Yes	No
4. Mobility: A person who has a condition which impairs the ability to use fine and/or gross motor skills to the extent that assistance of another person and/or mechanical device is needed in order for the individual to move from place to place.		

Comments

	Yes	No
5. Self-direction: A person who has a condition which requires that person to need assistance in being able to make independent decisions concerning social and individual activities and/or handling personal finances and/or protecting his/her own self-interest.		

Comments

	Yes	No
6. Capacity for Independent Living: A person who has a condition which limits that person from performing normal societal roles or which makes it unsafe for that person to live alone to such an extent that assistance, supervision or presence of a second person is required more than half the time (during waking hours).		

Comments

If three or more substantial functional limitations are not indicated, the consumer is not eligible.

F. Attendant Care Program Screening

	Yes	No
Can the Attendant Care Program appropriately serve the consumer?		

Comments

Please indicate whether or not the consumer had habilitation needs that if it were not for Waiver services, he or she would qualify for ICF/ORC level of care. Please list the consumer's needs that qualify him/her for ICF/ORC level of care.

H. Nursing Facility and Medical Assistance Eligible

	Yes	No
1. Is it anticipated that the consumer will be eligible for Medical Assistance?		
2. Is it anticipated that the consumer will be eligible for nursing facility services?		

I. Final Eligibility Screen

	Yes	No
1. Is there sufficient information about the consumer to determine general eligibility for the OSP/OBRA waiver (pending MA and OSP's determinations)?		

If "no" is checked, indicate additional information required to determine initial eligibility:

J. Referrals

Based on information provided, the consumer is not eligible for the OSP/OBRA. As a result, referrals were made to the following:

1.

2.

3.

Attachment E.

Certification of Disability Form
Reduced 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 Community Transit of Delaware County. If you have any questions about the form, please call 610-490-3977.

Applicant Information (to be completed by applicant):

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

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

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

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 eligibility information**)

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.

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Mobility disability (please see question to the right) | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Vision disability | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Hearing disability | <input type="checkbox"/> Motorized Scooter | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Cognitive disability | | |
| <input type="checkbox"/> Mental disability | | |
| <input type="checkbox"/> Other — Please specify: _____ | | |

Signature of Professional

Date

Title

Name of Agency or Organization

Address

Telephone

Please send completed form to: **Community Transit of Delaware County • 206 Eddystone Avenue • Eddystone, PA • 19022**

ATTACHMENT F

250% of the 2008 Federal Poverty Income Guidelines

Family Size	Monthly Limit	Annual Limit
1	\$2,167	\$26,000
2	\$2,917	\$35,000
3	\$3,667	\$44,000
4	\$4,417	\$53,000
5	\$5,167	\$62,000
6	\$5,917	\$71,000
7	\$6,667	\$80,000
8	\$7,417	\$89,000