Application for CT Shared Ride Paratransit Services

(MATP, Persons with Disabilities (PwD), ADA, Senior Shared Ride 65+, Public Full Fare)

1. CT is not a free service. Transportation services may be available at a reduced rate if you meet any of the following criteria:
   - Currently on Medical Assistance through Pennsylvania's Department of Human Services;
   - A person with a disability and aged 12-64;
   - A person who lives along the fixed route, but due to a disability is unable to access it;
   - Aged 65 or older.

2. If you would like to apply, please complete this form and send it (original or legible scanned copy, no faxes accepted) with a legible copy of the required proof of age document to the address below:

   Carbon Transit Applications
   1060 Lehigh Street
   Allentown, PA 18103
   CCCTapps@lantabus-pa.gov

   Important
   - All applicants must complete Parts 1, 4, 5, 6, 7 and 8.
   - If you have Medical Assistance through the Pennsylvania Department of Human Services, please complete Part 2.
   - If you have a disability, please complete Part 3 per the instructions given in Part 3.
   - You must include a proof of age with the application.

3. Once your application is received and reviewed, you will be notified, by mail, of your eligibility to participate.

4. If you have any questions about this application or need this form in an alternate format, please call:
   CT Shared Ride Paratransit Program Administration at (610) 432-3200

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 paratransit transportation services under the Persons with Disabilities and Senior Shared Ride programs.

Other information within the application will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and to provide you with the appropriate referral service (MATP, ADA).

This information will be kept confidential and used only by the professionals involved in evaluating your eligibility.

Ecolane ID #_____
Office Use Only

** PLEASE PRINT **

PART 1: GENERAL/QUALIFYING QUESTIONS

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

Address (Street and Number):_____

City:_____ State:_____ Zip Code:_____

County of Residence:_____ Gender:_____

Telephone: Home (____)_____ Cell (____)_____ Work ( )_____

E-Mail:_____

Social Security Number:_____ Date of Birth:_____ Age:_____

Acceptable proof of age documents (one required). Please send a legible photocopy of your proof of age along with this application. A Medicare card is not an acceptable proof of age.

1) Armed forces discharge/separation papers
2) Baptismal certificate
3) Birth certificate
4) PACE ID Card
5) Resident Alien Card
6) Passport/naturalization papers
7) Pennsylvania ID card (issued by DMV)
8) Photo motor vehicle driver's license
9) Veteran's Universal Access ID Card (date of birth must be on the card)
10) Statement of age from U.S. Social Security Administration

Emergency Contact

Name:_____

Relationship:_____

Telephone:_____

Is there anything else you would like us to know so we can serve you better? Yes_____ No_____

If YES, please describe:_____

Mobility Device

Please check mobility device (check all that apply):

_____Manual wheelchair
_____Motorized wheelchair
_____3 wheeled scooter
_____4 wheeled scooter
_____Guide dog/service animal
_____White cane
_____Personal care attendant (please complete certification below)

_____Cane
_____Walker
_____Prosthesis
_____Crutches
_____Leg braces
_____Portable oxygen

_____Other:_____

Brand name:_____

Personal Care Attendant Certification

CT does not provide personal care attendants (PCAs). If you require a PCA, you must provide your own and the PCA will ride for free whenever you need them to travel with you.

I certify that I need the services of a PCA to make independent travel possible. A PCA is someone, aged 12 or older, employed specifically to assist me with the completion of at least one daily life activity (as defined in Part 3) on a regular basis.

I will need a PCA (check one): _____permanently _____temporarily _____occasionally

Please describe the assistance to be provided by the PCA: _____

_____

_____

_____

If temporarily, please list the start and end dates when you will need the PCA:_____

If occasionally, provide the circumstances under which you will need the PCA:_____

_____

_____

PART 2: MEDICAL ASSISTANCE TRANSPORTATION PROGRAM INFORMATION

The **Medical Assistance Transportation Program**, also known as **MATP**, provides transportation to eligible medical appointments for Medical Assistance recipients who do not have transportation available to them. CT will determine which type of transportation is the least expensive to provide while still meeting their needs.

Your 10 digit MATP issued recipient number is required. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

I am requesting (check one):

_____Car mileage reimbursement (skip to page 8)

_____Fixed route bus service reimbursement (skip to page 8)

_____CT shared ride paratransit services

Do you have a vehicle in the household? Yes_____No_____Explain:_____

** 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 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 all attachments required for the determination of eligibility.

** I am authorizing that, in the event that the Service Provider must verify information regarding my trips from medical providers to which I am traveling, in order to comply with the Pennsylvania 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 are receiving the information.

Signature: _____ **Date**: _____

************FOR OFFICE USE ONLY************

Date of Service: _____

□ **EVS CHECKED and ATTACHED**

Health Care Benefit Code: _____

Mode Key: **P=**PUBLIC TRANSIT **S=** SHARED RIDE **A=**PRIVATE AUTO **V=**VOLUNTEER **O=**OTHER (See Svc. Notes)

MATP Funding Status: **GROUP 1** **GROUP 2** (D-00, D-05, B-00, PD-00, PD-21, PD-22, PD-29, TD-00, TD-11, TB-00)

Eligibility Status: **ELIGIBLE** **INELIGIBLE**

PART 3: ADA TRANSPORTATION PROGRAM

For individuals with disabilities who are unable to ride fixed route bus service, the ADA requires that paratransit services be provided at a level of service comparable to the fixed route system. Not all people with disabilities are eligible for ADA complementary paratransit services. Only those who are unable to access their fixed route system are eligible.

Paratransit services must be offered on the same days and same times fixed route service is offered. Paratransit must serve all areas within a corridor which extends ¾ of a mile on each side of each route served by the fixed route system.

DEFINITION OF DISABILITY

Eligibility for the program is based on disability as defined by the Americans with Disabilities Act (ADA). ADA definition of *disability*: "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."

Do you have a disability according to the Americans with Disabilities Act (ADA)? _____ Yes _____ No

HOME ENVIRONMENT

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

If no, why not?_____

How would you describe the terrain where you live? (Example: steep hill, flat, long gradual hill, etc.)

_____

Are there sidewalks in your neighborhood? _____Yes _____No

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY

In order to be eligible based on a disability, written verification by a qualified individual or organization that you are a person with a disability is **required** to participate in the ADA Program and the Rural Transportation for Persons with Disabilities Program. The more information provided, the better CT staff will be able to understand your ability, your travel challenges, and determine your eligibility. CT staff may need to talk to you to get more information.

Part 3A (preferred) **or** 3B is required to determine eligibility. It is your choice which section, 3A **or** 3B, you want to complete.

PART 3A: Certification of Disability

This part is to be completed by a professional who is familiar with your 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 persons with disabilities. You are applying for transportation services under the ADA Program and the Rural Transportation for Persons with Disabilities Program, which is being administered by the Pennsylvania Department of Transportation with services provided by CT. If you have any questions please call (610) 432-3200.

Applicant Information:

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

Address (Street & No.):_____

City:_____ State:_____ Zip Code: _____

Telephone Home: _____ Cell: _____ Work: _____

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."

What is the disability that prevents the applicant from using fixed route bus service?

How many blocks can this applicant walk unassisted? (Circle One) <1 1-2 2-3 6 9

Is the applicant's disability permanent? _____ Yes _____ No
(A standard definition of a permanent disability is one that lasts for 2 months or longer.)

If no, how long do you expect the applicant to have a disability? _____

Does their disability change much from day to day? _____ Yes _____ No

Does the weather affect their disability? _____ Yes _____ No

If yes, please explain _____

_____

What is the nature of the applicant's disability? Check those that apply.

_____Mobility disability
_____Vision disability
_____Hearing disability
_____Cognitive disability
_____Mental disability
_____Other — Please specify:_____

Please check all mobility aids that apply.

_____ Manual wheelchair
_____ Power wheelchair
_____ Motorized scooter
_____ Guide dog/service animal
_____ Other _____

_____ Crutches
_____ Cane
_____ Walker
_____ Oxygen

Signature of Professional	Printed Name	Date
Title		Name of Agency
Address		Telephone

Part 3B: Professional Verification of Disability

You will need to send written verification that you are disabled according to the ADA definition from one of the organizations or persons listed below. Please check which verification you are including.

_____Office of Vocational Rehabilitation (OVR)
_____Social Security Insurance (SSI) or Social Security Disability Insurance (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 4: DEMOGRAPHIC INFORMATION

This information is required for reporting purposes.

Ethnic Information:

_____White _____African American _____American Indian/Alaskan Native
_____Hispanic Origin _____Asian American/Pacific Islander

Yearly Income (please circle one):

For a 1 Member Household	Above $10,830	Below $10,830
For a 2 Member Household	Above $14,570	Below $14,570

Other Information:

Do you live alone? _____Yes _____No

Are you frail or functionally disabled? _____Yes _____No

Do you have adequate housing? _____Yes _____No

Please describe any effects of a disability of which we need to be aware:_____

_____

_____

PART 5: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the Persons with Disabilities Program are not to be provided in place of any current transportation services that you already receive.

Do you now receive any transportation services or are any of your transportation costs paid for by another program or organization? _____Yes _____No

Please check all that apply:

_____Senior Citizens Shared Ride Transportation Program
_____Area Agency on Aging
_____Medical Assistance Transportation Program
_____Americans with Disabilities Act Complementary Paratransit
_____Mental Health/Mental Retardation (MH/IDD)
_____Office of Vocational Rehabilitation (OVR)
_____Training/employment program
_____Group home where you live
_____Other:_____

PART 6: 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.

Please read the table below and complete the following. If you think you qualify, please contact us for more information.

You must check 1 of the lines below.

_____I am already registered with MATP

_____I have read the table below and think I may qualify for MATP

_____I have read the table below and DO NOT think I qualify for MATP

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES 2015 POVERTY GUIDELINES

Size of family unit	100 Percent of Poverty	110 Percent of Poverty	125 Percent of Poverty	150 Percent of Poverty	175 Percent of Poverty	185 Percent of Poverty	200 Percent of Poverty
1	$11,670	$12,837	$14,588	$17,505	$20,423	$21,590	$23,340
2	$15,730	$17,303	$19,663	$23,595	$27,528	$29,101	$31,460
3	$19,790	$21,769	$24,738	$29,685	$34,633	$36,612	$39,580
4	$23,850	$26,235	$29,813	$35,775	$41,738	$44,123	$47,700
5	$27,910	$30,701	$34,888	$41,865	$48,843	$51,634	$55,820
6	$31,970	$35,167	$39,963	$47,955	$55,948	$59,145	$63,940
7	$36,030	$39,633	$45,038	$54,045	$63,053	$66,656	$72,060
8	$40,090	$44,099	$50,113	$60,135	$70,158	$74,167	$80,180

For all states (except Alaska and Hawaii) and for the District of Columbia.
Note: For optional use in FFY 2014 and mandatory use in FFY 2015.

PART 7: RELEASE OF INFORMATION

I certify that the information contained in this application is correct and truthful to the best of my knowledge.

I give my permission to CT to contact a healthcare or other professional that I designate for additional information regarding my health. Yes_____ No _____

Name and telephone of professional who is familiar with my health _____

_____

_____ _____

Your Signature or the person who completed the application Date

PART 8: CERTIFICATION

I understand that I will be expected to make my own telephone calls to CT.

Check one:

_____ I am able to make my own telephone calls.

_____ I am unable to make my own telephone calls. I select the following individual to make all my CT telephone calls.

_____

Name of individual

I also understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by CT. I certify that this information contained in this application is correct and truthful to the best of my knowledge.

_____ _____

Your Signature or the person who completed the application Date

_____

Name of the person who completed this application Relationship Telephone