Allied Coordinated Transportation Services, Inc. (ACTS)
Transportation & Fleet Maintenance Facility
701 North Mercer Street
New Castle, PA 16101
724.652.5588
www.lccap.org/ACTS

Dear Potential Rider:

Following this letter is the application for the Rural Transportation for Persons with Disabilities (PwD) Program. This program is for any resident of Pennsylvania with a temporary or permanent disability that may be traveling within our service area.

Please print the **application** that follows. Please complete application and make sure you sign it. This application requires proof of your disability. If you do not have a prior certification of disability, page 5 of the application may be completed by your medical professional.

Please return both the completed application and proof of disability to **ACTS, 701 N Mercer Street, New Castle, PA 16101 or email to actscs@lccap.org or fax to 724-546-5160.**

You are also required to register under the Americans with Disabilities (ADA) Program. To receive the application for ADA please call the New Castle Area Transit Authority at 724-654-3130 press '0' and request an ADA application. When riding under the ADA Program you will also ride the ACTS buses.

If you have any questions regarding this application or any of our programs please feel free to contact ACTS Customer Service at 724-652-5588 option #1.

Sincerely,
ACTS Transportation Department

ALLIED COORDINATED TRANSPORTATION, INC.

701 N. Mercer Street
New Castle, PA 16101
Phone (724) 652-5588 Fax (724) 546-5160

SHARED RIDE PROGRAM FOR PERSONS WITH DISABILITIES (PwD)

Eligibility and Registration Form - Instructions for Applicant

The eligibility and registration form is a total of four pages. This form is also available in large print, and other formats (Braille and on tape). If you require an alternate format, contact the ACTS office. The following instructions summarize the major sections of the form and provide assistance in completing the form and providing the required documentation to the ACTS office.

Part 1: General Information

- Please print your name, address, and other identifying information on the form.
- Please answer the question of whether you have a disability according to the ADA definition by checking 'Yes' or 'No'.

Part 2: Written Verification That You Are A Person With A Disability

- You must provide written verification of a disability to be eligible for discounted shared-ride fares through the PwD project.
- If you have an existing written form of verification, submit such form with your completed application.
- If you do not have an existing written form of verification, please contact one of the organizations listed on page 2 of the registration form for confirmation of a disability OR use the Certification of Disability Form (Page 5) provided and submit form with your completed application.
- Please identify the organization providing the written verification of disability.

Part 3: Income and Household Related Data

- Please check the appropriate income range for your gross income. (Amount received before taxes)
- Please check the number of persons residing in your household.

Note: This information is required, but does not affect eligibility for PwD.

Part 4: Avoiding duplication of Transportation Services

- The PwD project is not to replace current transportation services.
- If current transportation services and costs are covered by another program, you must identify such programs from the list provided.

Note: Do not complete section number 2. ACTS staff will complete this section when necessary.

Part 5: Information So We May Serve You Better

- Please indicate if your disability is permanent or not based on the standard definition provided.
- If you do not have a permanent disability, please tell us how long the disability is expected to last.
- Place a check mark next to all of the listed disabilities that apply. (Attachment A provides a description of the three categories of disabilities)
- If you have a mobility disability, please check all of the mobility aids that are used.
- Please check if a personal care attendant or escort may be accompanying you during transportation.
- You should provide the name and contact information for an emergency contact (optional).
- Please describe anything else we need to know in order to assist you better.

Part 6: Release of Information and Your Certification of the Application Form

- The first section allows to obtain information about your disability from a health organization.
- You or the person completing form must sign and date authorizing the release of information.
- The next section certifies your understanding of the application process and validity of the information provided.
- You or the person completing form must sign and date confirming the certification statement.
- Please complete the name, relationship, and phone number of the person who completed the form.

** * * If you have questions regarding the application process, Please contact the ACTS office at (724) 652-5588. * * **

OFFICE USE ONLY:_____

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. Between 18 and 64 years old and
3. Need accessible public transit in a participating county beyond ADA complementary paratransit services.

If you believe that you may be eligible for this program and would like to receive transportation services through this program, please complete this form and send it with a copy of one of the documents listed in Part 2 to:

Allied Coordinated Transportation Services, Inc. (ACTS)
701 N. Mercer Street
New Castle, PA 16101

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

If you have questions about the PwD Program, this application, or if you need this application is an alternate format, please call: 724-652-5588 or 1-888-252-5104

NOTE: The information that you provide 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 this application will be used for data collection purposes, to determine your eligibility for any additional transportation sponsors, and to provide you with the appropriate type of service. This information will be kept confidential and used by professionals involved in evaluating your eligibility and analyzing the PwD Program 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: _____

Social Security #: (last 4 only) _____ Date of Birth: _____

County of Residence: _____

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?

_____ YES _____ NO

Definition of Disability

Eligibility for the PwD Program is based on disability as defined by the American with Disabilities 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 Program.

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 ACTS.

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 (SSDI)

_____ Bureau of Blindness and Visual Services

_____ Center for Independent Living (CIL)

_____ Mental Health/Mental Retardation Program (MH/MR)

_____ United Cerebral Palsy

_____ Physician

_____ Registered Physical / Occupational Therapist

_____ Registered Nurse

_____ PA Attendant Care Program

_____ Community Services Program for Persons with Physical Disabilities

_____ Other: _____

2. IF YOU DO NOT HAVE WRITTEN VERIFICATION OF A DISABILITY:

Please have the attached Certification of Disability Form (Page 5) completed by a qualified professional and return it to ACTS with this completed application. Since you do not have a verification if disability, this form must be completed to verify your disability according to the definition in the American with Disabilities Act.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

As required by the Pennsylvania Department of Transportation, ACTS must ensure that the following information is collected for all applicants so that it can be used or further decision-making regarding the PwD Program. **This information will not be used to determine eligibility for discounted fares under the PwD Program.**

Annual Household Income:

_____ Less than $10,000
_____ $10,001-$15,000
_____ $15,001-$20,000
_____ $20,001-25,000
_____ $25,001-$30,000
_____ $30,001-$35,000
_____ $35,001-$40,000
_____ $40,001-$45,000
_____ $45,001-$50,000
_____ $50,001-$55,000
_____ $55,001-$60,000
_____ $60,001+

Household Size:

_____ 1
_____ 2
_____ 3
_____ 4
_____ 5
_____ 6
_____ 7
_____ 8+

PART 4: AVOIDING DUPLICATION OF TRANSPORTATION SERVICES

Transportation services provided under the PwD Project are not to be provided in place of 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 check all that apply from the following list:

_____ Senior Citizen Shared-Ride Transportation Program
_____ Challenges/Options on Aging
_____ Medical Assistance Transportation Program
_____ Americans with Disabilities Act (ADA Complementary Paratransit)
_____ Lark Enterprises or Lawrence County ARC
_____ Office of Vocational Rehabilitation (OVR)
_____ The training program I am in at _____.
_____ The employment program I am in at _____.
_____ The group home, or personal care home where I live.
_____ Other (please explain)_____.

2. If you have a valid Medical Assistance Card through the Department of Public Welfare and are not registered for the Medical Assistance Transportation Program (MATP), you may qualify for free transportation services to your medical appointments. As part of ACTS eligibility process, your name will be referred to Lawrence County Social Services, Inc., the Medical Assistance Transportation Provider, if you have a valid Medical Assistance Card.

TO BE COMPLETED BY THE ACTS OFFICE:	Staff Member's Initials: _____
_____ No Referral- Applicant does not have a valid Medical Assistance Card	
_____ No Referral- Applicant does have a Medical Assistance Card and is already registered for MATP	
_____ REFERRAL- Applicant does have a valid Medical Assistance Card and is not registered for MATP	

PART 5: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent (expected to last longer than 12 months)?: _____ YES _____ NO

2. If your disability is temporary, how long is it expected to last? _____

3. What is the nature of your disability? Check all of those that apply:

_____ Mobility Disability
_____ Vision Disability
_____ Hearing Disability
_____ Cognitive Disability
_____ Mental Disability
_____ Other - Please specify:_____

4. Please check all mobility aids that apply:

_____ Manual Wheelchair
_____ Power Wheelchair
_____ Motorized Scooter
_____ Crutches
_____ Cane
_____ Walker
_____ Canine Assistant
_____ Other: _____

5. Do you require the Driver's assistance from the door of your residence and to the door of your destination or with grocery bags and other belongings?

_____ YES _____ NO

6. 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 a trip or at your origin or destination)

_____ YES
_____ NO
_____ SOMETIMES

Please describe when you need assistance: _____

_____

7. Emergency Contact (Optional)

Name: _____ Relationship: _____

Phone: Home: _____ Work: _____

8. Is there anything else you want us to know so that we are better able to serve you? YES _____
NO _____

If "YES", please explain:

_____

_____

_____

PART 6: RELEASE OF INFORMATION AND YOUR CERTIFICATION OF THE APPLICATION FORM

I give my permission to Allied Coordinated Transportation Services, Inc. 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 _____

_____
Applicant's 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 Program. I certify that the information contained in this application is correct and truthful to the best of my knowledge.

_____
Applicant's Signature or that of the Person Who Completed This Form Date

_____
Name of the Person who Completed this Form Relationship Telephone Number

Certification of Disability Form

Allied Coordinated Transportation Services, Inc.- Rural Transportation for Persons with Disabilities Program (PwD)

THIS FORM MUST BE COMPLETED IF THE APPLICANT DOES NOT HAVE A PRIOR CERTIFICATION OF DISABILITY AS DESCRIBED IN THE PWD APPLICATION. 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 American 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 Allied Coordinated Transportation Services, Inc. (ACTS). If you have any questions about this form, please call ACTS at 724-652-5588.

APPLICANT INFORMATION (to be completed by applicant or designee):

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

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

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

Applicant or Designee's Signature: _____ Date: _____

Definition of Disability

Eligibility for the PwD Program is based on disability as defined by the American with Disabilities 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."

VERIFICATION INFORMATION (to be completed by the agency or person providing verification of disability):

Is the applicant's disability permanent (will last longer than 12 months)? _____ YES _____ NO

If not, how long is the disability expected to last? _____

What is the nature of the applicant's disability?
(Please check all that apply)

_____ Mobility Disability
_____ Vision Disability
_____ Hearing Disability
_____ Cognitive Disability
_____ Mental Disability
_____ Other - Please specify:_____

Does the applicant use any type of mobility aids?
(Please check all that apply)

_____ Manual Wheelchair
_____ Power Wheelchair
_____ Motorized Scooter
_____ Crutches
_____ Cane
_____ Walker

_____
Signature of Professional Date

_____
Title Name of Agency or Organization

_____
Address of Agency or Organization Telephone Number

The applicant must return this form, along with the PwD Application, to: Allied Coordinated Transportation Services, Inc. (ACTS)

Attachment A

Three Categories of Disabilities

SHARED RIDE PROGRAM FOR PERSONS WITH DISABILITIES (PwD)

Disabilities are described in the following three categories:

1) Mental impairment, including developmental 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 ability 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 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.