



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 Senior Citizens' Transit Program Application. This program is for anyone residing within Pennsylvania who is 65 years of age or older.

Please print the **application** and the **letter** that follows. Please complete only the highlighted section of the application and make sure you sign it. Please complete the section below the dotted line of the letter that follows.

Please return both items as well as **proof of age** (one of the items from the list on the top half of the letter) to **ACTS, 701 N Mercer Street, New Castle, PA 16101** or email to **actscs@lccap.org** or fax to **724-546-5160**.

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



ACTS is a proud member of the Lawrence County Community Action Partnership



PENNSYLVANIA
Department of Transportation
www.dotstate.pa.us

**APPLICATION
SENIOR CITIZEN TRANSIT
IDENTIFICATION CARD**

FREE/REDUCED FARE
TRANSIT PROGRAMS FOR SENIOR CITIZENS

CARD NUMBER

| | | | | |
|---|---------------|---------------------|--|------------|
| NAME OF APPLICANT (Last, First, Middle Initial) | | | DATE OF APPLICATION | |
| ADDRESS (Street or Route) | | City or Post Office | (State) | (Zip Code) |
| HOME TELEPHONE NUMBER | DATE OF BIRTH | AGE | SIGN HERE | |
| AREA CODE | | | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE X | |

THIS SECTION TO BE COMPLETED BY TRANSIT AGENCY

ACCEPTABLE PROOF OF AGE DOCUMENTS (ONE REQUIRED, CHECK AND INCLUDE APPLICABLE INFORMATION)

- ☐ ARMED FORCES DISCHARGE/SEPARATION PAPERS (DD-214) _____
☐ BIRTH CERTIFICATE - NUMBER _____
☐ PASSPORT/NATURALIZATION PAPERS - NUMBER _____
☐ PENNSYLVANIA IDENTIFICATION CARD - NUMBER _____
☐ RESIDENT ALIEN CARD - NUMBER _____
☐ PHOTO MOTOR VEHICLE OPERATOR'S LICENSE - NUMBER _____
☐ STATEMENT OF AGE FROM UNITED STATES SOCIAL SECURITY ADMINISTRATION
 (ATTACH COPY TO THIS APPLICATION) _____

PLEASE NOTE THAT ONLY THE ABOVE FORMS OF AGE DOCUMENTATION ARE ACCEPTABLE FOR THESE PROGRAMS

I DO HEREBY CERTIFY THAT I HAVE REVIEWED THE ABOVE AGE DOCUMENTATION AND THE INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

SIGNATURE OF TRANSIT AGENCY REPRESENTATIVE CERTIFYING AGE DOCUMENTATION - DATE

PRINTED NAME OF ABOVE TRANSIT AGENCY REPRESENTATIVE

ALLIED COORDINATED TRANSPORTATION SERVICES, INC. (ACTS), 701 N MERCER STREET, NEW CASTLE, PA 16101

NAME OF TRANSIT AGENCY (Include Street or Route, City or Post Office, State Zip Code)



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Dear Potential Rider:

Enclosed is your application for the Senior Citizens' Transit Program. This is just a friendly reminder to **sign your application** and to enclose a photo copy of one of the following, showing proof of age:

1. Armed Forces Discharge/Separation Papers (DD-214)
2. Birth Certificate - Number
3. Passport / Naturalization Papers - Numbers
4. Pennsylvania Identification Card - Number
5. Photo Motor Vehicle Identification Card - Number
6. Statement of Age from the United States Social Security Administration

Return completed application with your proof of age to ACTS, Inc., 701 N. Mercer Street, New Castle, PA 16101. The sooner we receive your completed application, the sooner we can process your paperwork and get you started riding.

So that we can serve you better please complete the following and return with your completed application:

Please check all boxes that apply:

- | | |
|---|--|
| <input type="checkbox"/> Door to Door Assistance needed | <input type="checkbox"/> Lift Needed |
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Motorized Scooter |
| <input type="checkbox"/> Motorized Wheelchair | <input type="checkbox"/> Crutches / Cane |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Canine Assistant | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Other: _____ | |

If you would like to list an Emergency Contact Person, please complete:

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____



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