Bucks County Transport, Inc.

Eligibility and Registration Form
Rural Transportation for Persons with Disabilities (PwD) Program

Reduced fare transportation service may be available to you if you are:
1. A person with a disability age 18 – 64 and
2. Needs accessible public transit in Bucks County beyond ADA complementary paratransit services.

If you would like to participate in this program, please complete this form and send it with a copy of one of the documents listed in Part 2 below to:

Bucks County Transport, Inc.
P.O. Box 510
Holicong, PA 18928
Or
FAX 215-794-5564

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

If you have questions about this program, this form or need this form in an alternate format please call: 1-888-795-0740

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 in analyzing the pilot 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: _______________________  Cell: _______________ _____  E-mail: ________________

County of Residence __________ Date of Birth: ________________ SSN#:__________________________
Is your residence considered a Group Home or other Community Residential facility?
_____Yes      _____No
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."

DO NOT FILL OUT THIS SECTION – BCT STAFF ONLY

PwD Status:____________________  MA Status:____________________
Spec. Nds:______________________  Emerg. Contact__________________
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, attach a copy of that information to 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 back to Bucks County Transport, Inc. (Address is on Page 1). See # 2 below.

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

_____ Office of Vocational Rehabilitation (OVR)  _____ Registered Physical/Occupational Therapist
_____ Social Security Insurance (SSI) and Disability Insurance (SSDI)  _____ Physician
_____ Bureau of Blindness and Visual Services  _____ Registered Nurse
_____ Center for Independent Living (CIL)  _____ PA Attendant Care Program
_____ Mental Health/Developmental Program  _____ Community Services Program for Persons with Physical Disabilities
_____ United Cerebral Palsy  _____ Other: ______________________________________

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

Please fill out a Certification of Disability Form, Attachment G, Page 6. 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.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

Passenger income related data is being collected for further decision-making regarding the program. THIS INFORMATION WILL NOT BE USED TO DETERMINE ELIGIBILITY FOR DISCOUNTED FARES UNDER THE PwD PROGRAM. Please check the appropriate space in each column:

<table>
<thead>
<tr>
<th>Applicant Annual Income</th>
<th>Household Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>1</td>
</tr>
<tr>
<td>$10,001-$15,000</td>
<td>2</td>
</tr>
<tr>
<td>$15,001-$20,000</td>
<td>3</td>
</tr>
<tr>
<td>$20,001-$25,000</td>
<td>4</td>
</tr>
<tr>
<td>$25,001-$30,000</td>
<td>5</td>
</tr>
<tr>
<td>$30,000-$35,000</td>
<td>6</td>
</tr>
<tr>
<td>$35,001-$40,000</td>
<td>7</td>
</tr>
<tr>
<td>$40,001-$45,000</td>
<td>8</td>
</tr>
<tr>
<td>$45,001-$50,000</td>
<td>+</td>
</tr>
<tr>
<td>$50,001-$55,000</td>
<td></td>
</tr>
<tr>
<td>$55,001-$60,000</td>
<td></td>
</tr>
<tr>
<td>$60,001+</td>
<td></td>
</tr>
</tbody>
</table>
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.

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.

   _____ None/Does not apply – Skip to Part 5
   _____ Senior Citizens Shared-Ride Transportation Program
   _____ Area Agency on the Aging
   _____ Medical Assistance Transportation Program
   _____ Americans with Disabilities Act Complementary Paratransit
   _____ Mental Health/Developmental Program (MH/DP)
   _____ Office of Vocational Rehabilitation (OVR)
   _____ The training program I am in at ________________________________
   _____ The employment program I am in at ________________________________
   _____ The Residential Program where I live ________________________________
   _____ Other (please explain) ________________________________

Note: Checking multiple blocks above should not disqualify your eligibility for the PwD Program.

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.

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

All wheelchairs must be in functioning order and must meet certification requirements of BCT in advance of transportation. If a wheelchair becomes non-functioning while in transit, BCT will request assistance from the client’s emergency contact or will contact 911 for emergency professional assistance at the client’s expense.
5. Do you require the services of a personal care attendant or escort when you travel? If so, you must have a note from your medical professional stating that you require an escort. If an escort is required, the escort will ride at no charge.

____ Yes
____ No
____ Sometimes

Please describe when you need assistance: ____________________________________________________

6. Will a trained service animal be required to accompany you on your transportation trips?

____ Yes
____ No

If so, what type of animal ______________________

7. Emergency Contact

Name: ________________________________________________________________

Relationship: ________________________________________________________

Phone (Home): __________________________ (Work): __________________________

8. Please check all the destinations that apply to your transportation needs:

_____ Medical Appointments _______ Food Shopping ____________ ____ Other (Explain)

_____ Recreational _______ Employment

9. Please check an estimate of how many trips you plan to schedule per week:

_____ 1-2 per week _______ 2-5 per week _______ 6 or more per week

PART 6. CERTIFICATION OF THE APPLICATION FORM

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

Signature of Applicant___________________________________ DATE _____________________

OR, WITH THE APPLICANT’S PERMISSION

Signature of the person who completed this form ________________ DATE __________________

Print Name of the person who completed this form ________________________________

Relationship to Applicant __________________________________________________________
Attachment F

Release of Information

1. I ___________________ (Name of Applicant) do authorize _________________________(Name of Health Care Provider) to disclose to Bucks County Transport, Inc. such limited information from my medical records as is necessary to verify my disability for the specific and sole purpose of determining my eligibility for the PwD program.

This authorization will remain in effect for one year from the date signed unless revoked by me in writing. However, I understand that any actions taken in reliance of this authorization prior to receipt of my written revocation cannot be undone and are not in violation of law.

I further understand that there is a potential for information disclosed pursuant to this authorization to be disclosed by the recipient without the protections afforded by law and the covered entity to whom this authorization is directed cannot be liable for any further disclosures.

Signature of Applicant______________________________       Date________________
Attachment G

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 Bucks County Transport, Inc. If you have any questions about the form, please call 1-888-795-0740.

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.

_____ Mobility disability (please see question to the right) ____ Manual Wheelchair _______ Crutches

_____ Vision disability _______ Power Wheelchair _______ Cane

_____ Hearing disability _______ Motorized Scooter _______ Walker

_____ Cognitive disability

_____ Mental disability

_____ Other — Please specify: _____________________________

Signature of Professional Date

Title Name of Agency or Organization

Address Telephone

Please send completed form to: Bucks County Transport, Inc. P. O. Box 510 Holicong, PA 18928 Or fax to 215-794-5564