Reduced Fare Transportation Services
for Persons with Disabilities (PwD) Program and Americans with Disabilities Act Complementary Paratransit

◆ Reduced fare transportation service may be available to you if you are a person with disability.

◆ Please complete this form and send it with a copy of one of the documents listed in Part 2 below to:
Alliance for Nonprofit Resources Inc
130 Hollywood Drive, Suite 102
Butler, PA 16001
Attn: BART

◆ 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:
724-282-6060

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 and/or ADA Paratransit. 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 program or ADA paratransit.

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.

_____ 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

_____ United Cerebral Palsy

_____ Registered Physical/Occupational Therapist

_____ Physician

_____ 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 fill out a certification of disability form attached to this application (Attachment F). 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 Attachment F in this package.

PART 3: INCOME AND HOUSEHOLD RELATED DATA

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

Annual Income

_____ Less than $10,000
_____ $10,001-$15,000
_____ $15,001-$20,000
_____ $20,001-$25,000
_____ $25,001-$30,000
_____ $30,000-$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 program or Americans with Disabilities Act Complementary Paratransit 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
_____ 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 (Optional)

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 Alliance for Nonprofit Resources and Butler Transit Authority 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 program and/or the Americans with Disabilities Act Complementary Paratransit. 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

Certification of Disability Form

Reduced Fare Transportation Services
for Persons with Disabilities (PwD) Program and Americans with Disabilities Act Complementary Paratransit

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 profession 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 ***BART***. If you have any questions about the form, please call ***724-282-6060.***

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.

_____ Mobility disability (please see question to the right)
_____ Vision disability
_____ Hearing disability
_____ Cognitive disability
_____ Mental disability
_____ Other — Please specify: _____

Please check all mobility aids that apply.

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

_____
Signature of Professional Date

_____
Title Name of Agency or Organization

_____
Address Telephone

Please send completed form to: ***Alliance for Nonprofit Resources 130 Hollywood Drive Suite #102 Butler, PA 16001***

PREFERENCE FORM

NAME (Please Print Last Name, First, M.I.)

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE TODAY?

☐Yes

☐ No OR ☐ No, I am already registered to vote where I live now.

IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

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If you apply to register to vote, the office at which you submit this registration application form will remain confidential.

No information relating to a declination to register to vote will be used for any purpose other than for voter registration.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

In order to be qualified to register to vote, you must be at least 18 years of age on the day of the next election, you must have been a citizen of the United States for at least one month prior to the next election and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the **Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office Building, Harrisburg, PA 17120, or call the Department of State, toll-free, at 1-877-VOTESPA (1-877-868-3772).**

_____ _____

(Signature) (Date)