AREA TRANSPORTATION AUTHORITY OF NORTH CENTRAL PENNSYLVANIA
Cameron, Clearfield, Elk, Jefferson, McKean, Potter
44 TRANSPORTATION CENTER JOHNSONBURG PA 15845-2102

Application for Transportation Services

Medical Assistance Transportation Program for Cameron, Elk and McKean Counties (MATP)
Transportation Program for Persons with Disabilities (PwD)
ADA, Senior Shared Ride 65+, Public Full Fare

1. Transportation services may be available at a reduced rate, if you meet any of the following criteria:
   - You are currently on Medical Assistance through the Department of Human Services
   - You are a person with a disability between the ages of 18-64
   - You are a person who lives along a fixed route, but due to a disability cannot access it
   - You are aged 65+
2. If you would like to apply, please complete the application for transportation services and send it with any copies of qualifying documents to the address below.

AREA TRANSPORTATION AUTHORITY (ATA)
44 TRANSPORTATION CENTER
JOHNSONBURG, PA 15845-2102

3. Applications are processed in the order in which they are received.
4. For ADA customers, if we have not processed your application within 21 days of receipt, you will be given presumptive eligibility until we are able to make an eligibility determination.
5. Incomplete of missing information or documents will delay processing.
6. Once processed, you will receive a letter notifying you that you are eligible.

If you have any questions or need this application in an alternate format, please call **Customer Service at 1-866-282-4968.**

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 transportation services under various programs including the Transportation for Persons with Disabilities and Senior Shared Ride programs.

Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and provide you with the appropriate referral service (MATP, ADA, MD/IDD). This information is kept confidential and is used only by the professionals involved in evaluating your eligibility.

Please Print Ecolane ID: _____

How did you first learn about ATA's paratransit system?	
__ Hospital/Clinic Flyer	__ Saw an ATA Bus
__ Friend/Family Member	__ Senior Center
__ Case Worker	__ Advertisement
__ ATA's Information Booth (at Community Events)	__ Other: (Specify) _____ __ On-line

GENERAL / QUALIFYING QUESTIONS			
First Name:	Middle Name:		Last Name:
Date of birth:	SSN:		Age:
Current address:			
City:	State:	Zip code:	Email:
Home Phone:	Cell Phone:		County:
Emergency Contact:	Relationship:		Phone #:

AGE VERIFICATION: Please send a legible photocopy of one of the listed forms of proof of age along with this application **A Medicare card is not an acceptable proof of age.** Please check which verification you are enclosing.	
__ Armed forces discharge/separation papers	__ Pennsylvania ID card #_____
___ Passport/naturalization papers	__ Photo driver's license #_____
__ Baptismal certificate	__ Birth certificate (Maiden Name) _____
__ PACE ID Card	__ Veteran's Universal Access ID Card
__ Statement of age from U.S. Social Security Office	__ Resident Alien Card

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY- ONLY IF YOU ARE UNDER 65 YEARS OF AGE			
In order to be eligible based on a disability, the Certification of Disability must be completed by a qualified individual from one of the organizations listed below that you are a person with a disability and are **required** to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.			
Office of Vocational Rehabilitation (OVR)	*Bureau of Blindness and Visual Services*		*Registered Nurse*
Disability Insurance (SSDI)	*United Cerebral Palsy*	*PA Attendant Care Program*	*Physician*
Community Services Program for Persons with Physical Disabilities		*Registered Physical/Occupational Therapist*	
Mental Health/Intellectual & Developmental Disability (MH-IDD)	*Center for Independent Living (CIL)*	*Other* _____	

NEEDS ASSESSMENT		
What is your primary language?		
Do you have a medical assistance card? __ Yes __ No		
Do you have a disability according to the Americans w/ Disabilities Act (ADA)? If yes, attach the ***Certification of Disability Form***		
Do you have any mobility devices such as…		
___ Manual Wheel Chair	___ Oxygen	___ Cane
___ Motorized Scooter	___ Power Wheel Chair	___ Walker
___ Crutches	___ Guide Dog	Other_____
Do you require the services of a personal care assistant or escort when you travel? (Someone that is needed to assist you during the trip or at the origin or destination) ___ Yes ___ No ___ Sometimes		

RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION

By signing below, I hereby agree to report any changes to this Service Provider regarding my eligibility for funding assistance. I understand that giving knowingly false statements is a criminal offense 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 of person completing this form _____Date:_____

Please be sure to include the following with your application	**___ Proof of Age**
	___ Certificate of Disability (Page 6)
	___ Ensure your application is signed

CURRENT TRAVEL		
Do you currently use ATA's **fixed route** bus services? __ Yes __ No ___ Sometimes		
Does the weather affect your ability to use ATA's fixed route bus service? Yes ___ No ___ If yes, please explain:		
List your most frequent destinations and how you get there now		
Destination address where you go	How often do you go there?	How do you get there?
1.		
2.		

ENVIRONMENT AROUND YOUR RESIDENCE
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
How would you describe the terrain where you live? ___ Steep ___ Hill ___ Paved Lane ___ Unpaved lane
Are there sidewalks in your neighborhood? ___Yes ___ No

MOBILITY FUNCTIONAL ASSESSMENT

For each below question, check ***one*** answer. Your answers should be based on: how you feel most of the time; under normal circumstances; using your mobility equipment; and whether you can perform this activity independently.

Without the help of someone else, can you:

Walk up and down three steps if there are handrails on both sides?	___Always	___Sometimes	___Never	___Unsure
Use the telephone to get information?	___Always	___Sometimes	___Never	___Unsure
Cross the street if there are curb cuts?	___Always	___Sometimes	___Never	___Unsure
Ride up and down a wheelchair lift with handrails on both sides?	___Always	___Sometimes	___Never	___Unsure
Find your way to the bus stop if someone shows you the way?	___Always	___Sometimes	___Never	___Unsure
Currently travel by yourself?	___Always	___Sometimes	___Never	___Unsure
Wait 10 minutes in good weather outdoors without a place to sit?	___Always	___Sometimes	___Never	___Unsure
Step on and off the curb from a sidewalk?	___Always	___Sometimes	___Never	___Unsure
Travel up or down a gradual hill on the sidewalk, in good weather?	___Always	___Sometimes	___Never	___Unsure
Travel 3 level blocks, on the sidewalk, when the weather is good?	___Always	___Sometimes	___Never	___Unsure
If you are able to do this, how long does it take you?	__< 5 min	__5 – 10 min	__ > 10	___Unsure
Have you ever gotten lost when traveling alone?	___Yes		___No	

If the weather is good and there are no barriers in the way, what is the farthest you can walk or travel outdoors on a level sidewalk, using your mobility aid? (Please select the box which most closely your answer)

___ I cannot travel alone	___ Less than 1 block	___ 3 blocks	___ 6 blocks
___ Curb in front of house	___ 9 blocks	___ More than 9 blocks	Other_____

DUPLICATION OF TRANSPORTATION SERVICES	
Do you currently receive any transportation services? ___ Yes ___ No	
Are any of your transportation costs paid for by another program or organization? (Select from below all that apply)	
___ Senior Citizens Shared Ride Transportation Program	___ Office of Vocational Rehabilitation (OVR)
___ Medical Assistance Transportation Program	___ Mental Health/Mental Rehabilitation (MH/IDD)
___ Americans w/Disabilities Act Complementary Paratransit	___ Area Agency on Aging
___ Group Home (Where you live)	___ Other_____

ADA Applicants: If you are Applying Specifically for ADA Services, the Application Ends HERE.

All Other Applicants: Please Complete the Remainder of this Application.

DEMOGRAPHIC INFORMATION The following information is not required for Shared Ride to sponsor 85% of your trip fare. This information is required by the Offices for Aging, Inc. for reporting purposes.	
Ethnic Information: White ___ African American___ Am Indian/Alaskan Native___ Asian American/Pacific Islander___ Hispanic Origin___	
Do you live alone? ___Yes ____ No	Do you have adequate housing? ___Yes ____ No

MEDICAL ASSISTANCE INFORMATION (if applicable)	
Access Card #----------_ _	
Recipient # _____	Card Issue # _____
Do you have a vehicle in the household? __ Yes __ No	Who owns the vehicle?
Do you receive any of the following services?	___ Methadone ___ Dialysis ___ After School Services ___ Other_____

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***
After reviewing the chart below I think that… ____ I'm already registered with MATP _____ I may qualify for MATP _____I do not think I qualify for MATP

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES 2021 POVERTY GUIDELINES				
Household Size (select one)		**Annual Income (select one)**		
___1	___ 2	___ less than $14,820	___$14,821 - $20,040	___$20,041 - $25,260
___ 3	___ 4	___ $25,261 - $30,480	___$30,481 - $35,700	___$35,701 - $40,920
___ 5	___ 6	___ $40,921 - $46,140	___ $46,141-$51,360	
__ 7	__ 8	For families/households with more than 8 persons, add $5,220 for each additional person.		

RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION
I certify that the information contained in this application is correct and truthful to the best of my knowledge. I understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by ATA.
I give my permission to ATA to contact a healthcare or other professionals that I designate for additional information to verify that I am a person with a disability. ___Yes ____ No
By signing below, I hereby agree to report any changes in circumstances immediately to this Service Provider regarding my eligibility for funding assistance. 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 this application and 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 PA 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. Your signature (or name person who completed this form) _____ Date:_____ Relationship:_____ Contact Number:_____ **MAILING INSTRUCTIONS: Please check the following before mailing your application** **___ Include a copy of ONE form of proof of age** **___ Include a copy of any other important documents such as the Certification of Disability Form on Page 6** **___ Sign the Release of information and Certification of Application section**

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY			
In order to be eligible based on a disability, the Certification of Disability (last page) must be completed by a qualified individual from one of the organizations listed below that you are a person with a disability is **required** to participate in the Rural Transportation for Persons with Disabilities Program and the ADA program.			
Office of Vocational Rehabilitation (OVR)	*Bureau of Blindness and Visual Services*		*Registered Nurse*
Disability Insurance (SSDI)	*United Cerebral Palsy*	*PA Attendant Care Program*	*Physician*
Community Services Program for Persons with Physical Disabilities		*Registered Physical/Occupational Therapist*	
Mental Health/Mental Retardation Program (MH-MR)	*Center for Independent Living (CIL)*		*Other* _____
Information contained in this application will be kept confidential and shared only with professionals involved in evaluating your eligibility and appropriate ATA personnel. ATA staff may need to talk to the applicant later to get more information.			

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Certification of Disability Form

Persons with Disabilities Program (PwD) and Americans with Disabilities Act Program (ADA)

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 Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by the Area Transportation Authority (ATA). If you have any questions about the form, please call **ATA Customer Service at 1-866-282-4968.**

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 or Applicant Representative signature Date

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans 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."

Please answer the following questions **to be completed by the agency or person providing verification of eligibility information:**

How many blocks can this person walked unassisted? (Circle One) <1 block 1-2 blocks 2-3 blocks 6 blocks 9 blocks

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
_____ Guide/Service Dog _____ White Cane
_____ Requires Personal Assistant (nurse, health aide, etc.)
_____ Requires Escort

_____

Signature of Professional Date

_____

Title Name of Agency or Organization

_____

Address Telephone

Please send completed certification form to:

AREA TRANSPORTATION AUTHORITY (ATA)
44 TRANSPORTATION CENTER, JOHNSONBURG, PA 15845-2102

(07-01-22)