



Rural Transportation for Persons with Disabilities

1. Reduced fare transportation service may be available to you if you are:
 - a. A person with a disability and
 - b. Are under 65 years old and
 - c. Live in a county participating in the Rural Transportation for Persons with Disabilities program and
 - d. Need transportation to or from an area that is not currently served by the public fixed route bus transportation and ADA Complementary Paratransit services.
2. If you would like to participate in this project, please complete this form and send it with a copy of one of the documents listed in Part 2.



1230 Roosevelt Ave.
York, PA 17404

3. Once your application is received and reviewed you will be notified of your eligibility to participate.
4. If you have any questions about this project, this form or need this form in an alternate format please call:

Mobility Planning
(717) 849-0703 or 1-800-632-9063

NOTE: The information provided in this application regarding your disability will be used to determine your eligibility for reduced fare transportation services under the Rural Transportation for Persons with Disabilities program.

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 type service.

This information will be kept confidential and used only by the professionals involved in evaluating your eligibility and in analyzing the project for future recommendations.

*** PLEASE PRINT ***

PART 1: GENERAL

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

Address (Street & Number): _____

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)?

YES _____ NO _____

ADA definition of *disability*:

"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

Written verification by a knowledgeable organization or qualified individual that you are a person with a disability is required to participate in the Rural Transportation for Persons with Disabilities Program.

You will need to send verification from one of the organizations or person listed below. Please check which verification you are enclosing.

- 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
- Registered Physical/Occupational Therapist
- Physician
- Registered Nurse
- PA Attendant Care Program
- Community Services Program for Persons with Physical Disabilities
- Other _____

PART 3: INFORMATION TO SERVE YOU BETTER

1. Is your disability permanent? YES _____ NO _____
Standard definition of a permanent disability is one that lasts 12 months or longer.

2. If **NO** how long is it expected to last? _____

3. What is the nature of your disability? (Check those that apply)

_____ **Mobility Disability** (please check all that apply)

_____ Manual wheelchair

_____ Crutches

_____ Power wheelchair

_____ Motorized scooter

_____ Walker

_____ Cane

_____ **Vision Disability**

_____ **Hearing Disability**

_____ **Cognitive Disability**

_____ **Mental Disability**

_____ **Other** (please specify): _____

4. Do you require the services of a personal care attendant or escort when you travel?
(Someone that is needed to assist you during the trip or at the origin or destination)

YES _____ NO _____ SOMETIMES _____

Describe when you need the assistance: _____

PART 6. INCOME AND HOUSEHOLD RELATED DATA

If you are NOT registered for the Medical Assistance Program (MATP), you may qualify, and this program could pay all of the cost for your eligible trips to medical appointments.

Please read the table below and complete the following. If you think you qualify, we will contact you with more information.

_____ I am already registered with MATP

_____ I have read the table below and think I may qualify for MATP

_____ I have read the table below and DO NOT think I qualify for MATP

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES 2009 POVERTY GUIDELINES

Size of Family Or Budget Group Unit	Poverty 100%	Poverty 125%	Poverty 150%	Poverty 200%	Poverty 250%
1	\$10,830	\$13,538	\$16,245	\$21,660	\$27,075
2	\$14,570	\$18,213	\$21,855	\$29,140	\$36,425
3	\$18,310	\$22,888	\$27,465	\$36,620	\$45,775
4	\$22,050	\$27,563	\$33,075	\$44,100	\$55,125
5	\$25,790	\$32,238	\$38,685	\$51,580	\$64,475
6	\$29,530	\$36,913	\$44,295	\$59,060	\$73,825
7	\$33,270	\$41,588	\$49,905	\$66,540	\$83,175
8	\$37,010	\$46,263	\$55,515	\$74,020	\$92,525
For Family or Budget Group Units with more than 8 members, add for each additional member	\$3,740	\$4,675	\$5,610	\$7,480	\$9,350