

**Application for Veterans Transportation Services**

Ecolane ID: \_\_\_\_\_\_

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| **GENERAL / Qualifying Questions** | | | | | | | | | |
| First Name: | Middle Name: | | | Last Name: | | | | Phone: | |
| Date of birth: | SSN: | | | | Age: | | Email: | | |
| Street: | | City: | | | State: | Zip code: | | | County: |
| Emergency Contact Name: | | | Relationship: | | | | Phone #: | | |

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| **AGE VERIFICATION** Please send a legible photo copy 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 | | Statement of age from U.S. Soc Sec Office | |
| Photo motor vehicle driver’s license | Passport/naturalization papers | | | | Veteran’s Universal Access ID Card | |
| Birth certificate (Maiden Name\_\_\_\_\_\_ | | PACE ID Card | | Baptismal certificate | | Resident Alien Card |

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| **NEEDS ASSESSMENT** | | | | | | | | |
| Do you have a Pennsylvania 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*** | | | | | | | | |
| Please check any mobility devices that you use | | \_\_\_ Cane | \_\_\_ Walker | | \_\_\_ Crutches | \_\_\_ Guide Dog | | \_\_\_ Oxygen |
| \_\_\_ Wheel Chair | \_\_\_ Power Wheel Chair | | | \_\_\_ Electric Scooter | | | 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 | | | | | | | | |

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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **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 \_\_\_\_\_\_\_\_\_* |

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| **Before you submit please check to see if you have included the following…** | **\_\_\_ Proof of Age** | **\_\_\_Certificate of Disability** | **\_\_\_Signed Application** |