Application for Transportation Services  
(Veterans Services, MATP, Persons with Disabilities (PwD), ADA, Senior Shared Ride- 60-64 / 65+, Public Full Fare)

1. Transportation services may be available at a reduced rate, if you meet any of the following criteria:
   • You served in the armed services
   • 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 60 – 64 and live in a county serviced by rabbittransit
   • 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.

   rabbittransit
   415 Zarfoss Drive
   York, PA 17404

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, a Mobility Planner will contact you to notify you of your eligibility.

If you have any questions or need this application in an alternate format, please call Mobility Planning at 1-800-632-9063.

NOTE: The information provided in this application regarding your veteran status, age, disability, and county of residence will be used to determine your eligibility for shared ride transportation services under various programs including the Rural 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 rabbittransit’s paratransit system?

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GENERAL / QUALIFYING QUESTIONS

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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 #:
RERELEASE 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  
___ Proof of Veteran Status  
___ Certificate of Disability (Page 6)  
___ Ensure your application is signed

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
___ Passport/naturalization papers  ___ Photo motor vehicle 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

VETERAN SERVICE VERIFICATION: Please send a legible photo copy of proof of veteran service with this application  
Please check which verification you are enclosing.

___ Armed forces discharge/separation papers  ___ Veteran’s Universal Access ID Card
___ DD-214  ___ Driver’s License with Veteran’s Designation

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  
___ Proof of Veteran Status  
___ Certificate of Disability (Page 6)  
___ Ensure your application is signed
Veteran Applicants: If you are Applying for Only Veterans Services, the Application Ends HERE!
All Other Applicants: Please Complete the Remainder of this Application!

CURRENT TRAVEL
Do you currently use rabbittransit fixed route bus services? ___ Yes ___ No ___ Sometimes
Does the weather affect your ability to use rabbittransit fixed route bus service? Yes ___ No ___
If yes, please explain:

List your most frequent destinations and how you get there now

<table>
<thead>
<tr>
<th>Destination address where you go</th>
<th>How often do you go there?</th>
<th>How do you get there?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
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</tbody>
</table>

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________________________________________________

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

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

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

<table>
<thead>
<tr>
<th>Household Size (select one)</th>
<th>Annual Income (select one)</th>
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<tr>
<td><strong>1</strong> ___ 2</td>
<td>___ less than $14,820</td>
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<tr>
<td><strong>3</strong> ___ 4</td>
<td>___ $25,261 - $30,480</td>
</tr>
<tr>
<td><strong>5</strong> ___ 6</td>
<td>___ $40,921 - $46,140</td>
</tr>
<tr>
<td><strong>7</strong> ___ 8</td>
<td>For families/households with more than 8 persons, add $5,220 for each additional person.</td>
</tr>
<tr>
<td><strong>2</strong> ___ 3</td>
<td>___ $14,821 - $20,040</td>
</tr>
<tr>
<td><strong>4</strong> ___ 5</td>
<td>___ $30,481 - $35,700</td>
</tr>
<tr>
<td>___ $46,141-$51,360</td>
<td>___ $20,041 - $25,260</td>
</tr>
<tr>
<td>___ $35,701 - $40,920</td>
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</tr>
</tbody>
</table>

Edited June 2021
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  ___ STAP-Camp Name
                                          ___ After School Services  ___ Other_______________________

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 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 give my permission to rabbittransit to contact a healthcare or other professional(s) 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
                      ___ Sign the Release of information and Certification of Application section

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 _____________

Have you ever received training to learn how to use the bus or travel around the community? ___Yes ___No

If yes, which agency or person provided the training? ____________________________

When were you trained? ____________________________

Did you successfully complete the training? ___Yes ___No

If no, why not?

Was your training route specific? ___Yes ___No

Which routes did you learn?

Would you like to participate in training to learn to ride the bus? ___Yes ___No

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 rabbittransit personnel. rabbittransit staff may need to talk to the applicant later to get more information.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ___Yes ___No ___No, I am already registered to vote where I live now.
Certification of Disability Form
Reduced Fare Transportation Services
Transportation for Persons with Disabilities (PWD) and ADA 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 Transportation for Persons with Disabilities (PWD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by Central Pennsylvania Transportation Authority. If you have any questions about the form, please call 717-846-RIDE (7433) or toll free at 1-800-632-9063.

Applicant Information to be completed by applicant (A completar por el solicitante):

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 (Hecho por profesional):

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. 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  _____ Guide/Service Dog  _____ White Cane

_____ Mental disability  _____ Requires Personal Assistant (nurse, health aide, etc.)

_____ Other — Please specify: ______________________________________________

_____ Requires Escort

Signature of Professional  Date
________________________________________________________________________________________________________

Title  Name of Agency or Organization

Address  Telephone

Please send completed form to:
rabbittransit
415 Zarfoss Drive, York, Pa. 17404