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?

| __ Hospital/Clinic Flyer |   | __ Saw a Bus |
| __ Friend/Family Member |   | __ Senior Center |
| __ Case Worker |   | __ Advertisement: (Publication) |
| __ rabbittransit’s Information Booth (Prime of Life, Expos, Mall) |   | __ Other: (Specify) |

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 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
Destination address where you go  How often do you go there?  How do you get there?
1.
2.

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?  ___ Yes  ___ No
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>
</tr>
</thead>
<tbody>
<tr>
<td>_<strong>1</strong> ___2</td>
<td>___ less than $14,820 ___ $14,821 - $20,040 ___ $20,041 - $25,260</td>
</tr>
<tr>
<td>_<strong>3</strong> ___4</td>
<td>___ $25,261 - $30,480 ___ $30,481 - $35,700 ___ $35,701 - $40,920</td>
</tr>
<tr>
<td>_<strong>5</strong> ___6</td>
<td>___ $40,921 - $46,140 ___ $46,141-$51,360</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>
</tbody>
</table>

Edited June 2021
MEDICAL ASSISTANCE INFORMATION (if applicable)

Access Card # __ __ __ __ __ __ - __ __ __ __ __ __ __ __ - __ __ __ __ __ __
Address # __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

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 the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by rabbittransit.

I give my permission to rabbittransit 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
___ 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
g_____________

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
g_____________

Title __________________________________________  Name of Agency or Organization __________________________________________
Address ________________________________________  Telephone __________________________________________

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