

PERSONAL CARE ASSISTANT FORM

**APPLICANT – PLEASE COMPLETE THE TOP PORTION OF THIS FORM**

Date:

Name of applicant:

Last First MI

Address:

Street City State Zip

Are you able to use the fixed route bus? Yes

Do you require curb to curb service? Yes Do you require an escort when you travel? Yes

No No No

**PLEASE HAVE YOUR PHYSICIAN COMPLETE THE SECTION BELOW**

The person’s disability can generally be described as (please print or type information):

1. The disability will last longer than twelve months

2. The disability is temporary and can be expected to last until /

Month Year

Under what conditions is an escort required?

Name of physician: Address:

Phone No.:

Physician’s Signature:

**WHEN PROPERLY COMPLETED, PLEASE MAIL OR FAX TO**:

CUSTOMER SERVICE FAX NO. 717-848-4853 RABBITTRANSIT

415 ZARFOSS DRIVE

YORK, PA 17404