(724) 832 - 2706

GO WESTMORELAND DISABILITY TRANSPORTATION SERVICES

GO Westmoreland Disability Transportation Applicant

Part 1(General) and Part 2(Certification of Eligibility) needs completed by either the disabled applicant or by someone completing the form for him or her.

Part 3(Professional Verification) needs entirely completed by the medical professional that treats the applicants disability.

Completed applications can be returned by:

Email: info@westmorelandtransit.com

Fax: 724-853-2760

Mail: GO Westmoreland
203 Avenue B
Youngwood PA 15697

Please note the review process can take up to 21 days. The applicant will be contacted with the results of the eligibility determination in writing via US Mail.

Eligibility and Registration Form
Disability Transportation Services

- Americans with Disabilities (ADA) Complementary Paratransit Service may be available to you if:
  1) You are a person with a disability and
  2) You need transportation that could normally be made on a Westmoreland Transit fixed-route bus.

- Persons with Disabilities (PwD) Service may be available to you if:
  1) You are a person with a disability and
  2) You are under the age of 65 and
  3) You need transportation to or from an area that is not currently served by a Westmoreland Transit fixed-route bus.

Note: The information provided in this application regarding your disability will be used to determine your eligibility for Disability Transportation Services. Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and to provide you with the appropriate type of service**.** This information will be kept confidential and used only by professionals involved in evaluating your eligibility. Please print clearly.

PART 1: GENERAL

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

Address (Street & No.): _____

City: _____ State:_____ Zip Code: _____

Home Phone Number _____ Cell Phone Number _____

County of Residence: _____ Date of Birth: _____

Do you have a disability according to the Americans with Disabilities Act (ADA) definition below?

____ Yes ____ No

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disability 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."

PART 2: REQUEST FOR CERTIFICATION OF ELIGIBILITY (To be completed by the Applicant)

The information obtained in this Certification process will only be used by GO for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

1. Are you currently riding any Westmoreland Transit buses? [ ] YES [ ] NO

2. If no, what is the disability which prevents you from using our fixed-route service?

_____

_____

_____

Is this condition temporary? _____ If yes, expected duration until ____/____/____

3. How does this disability prevent you from using our fixed-route services? Please explain completely.

_____

_____

_____

4. Are there any effects of you disability of which we need to be aware? _____

5. Do you use any of the following mobility aides? (Check all that apply)

[ ]	Manual Wheelchair	[ ]	Powered Scooter
[ ]	Cane	[ ]	Personal Care Attendant
[ ]	Crutches	[ ]	Guide Dog
[ ]	Electric Wheelchair	[ ]	Other:

6. If you use a wheelchair, can you transfer with little assistance into a car? [ ] YES [ ] NO

Your Weight: _____ lbs. Weight of mobility aide: _____ lbs.

7. Do you require a Personal Care Attendant when you travel using transit? [ ] YES [ ] NO

8. Please answer the following questions:

Can you travel 200 feet without the assistance of another person?
[ ] YES [ ] NO [ ] Sometimes

Can you travel 1/4 mile without the assistance of another person?
[ ] YES [ ] NO [ ] Sometimes

Can you travel 3/4 mile without the assistance of another person?
[ ] YES [ ] NO [ ] Sometimes

Can you climb three (3) 12-inch steps without assistance?
[ ] YES [ ] NO [ ] Sometimes

Can you wait outside without support for ten (10) minutes? [ ]
YES [ ] NO [ ] Sometimes

WHO MAY BE CONTACTED IN THE EVENT OF AN EMERGENCY?

Name _____ Phone_____

Relationship to Applicant _____

9. I hereby certify that I have reviewed and understand the Disability Transportation Eligibility Rules and Regulations and that the information given in the Certification of Eligibility is true and correct to the best of my knowledge.

Signature of Applicant_____ Date_____

IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION, THAT PERSON MUST COMPLETE THE FOLLOWING:

Name_____ Date_____

Signature_____ Phone Number_____

The information provided in this application regarding your disability will be used to determine your eligibility for transportation services. Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and to provide you with the appropriate type of service. This information will be kept confidential and used by professionals involved in evaluating your eligibility.

PART 3: REQUEST FOR PROFESSIONAL VERIFICATION (To be completed entirely by the Physician)

RE: _____
(Applicant's Full Name)

The below authorization form has been submitted by the above named Applicant, who has indicated that you can provide information regarding his/her disability and its impact upon his/her ability to utilize our transit services. Federal law required that GO provide paratransit services to persons who cannot utilize available fixed-route services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests. Thanks you for your cooperation in this matter.

CAPACITY IN WHICH YOU KNOW THE APPLICANT: _____

Medical diagnosis of condition causing disability: _____

_____

Is this condition temporary? YES [ ] NO [ ]

If yes, expected duration until? _____/_____/_____

If the person has a disability effecting mobility, is the person:

Using any mobility aids? YES [ ] NO [ ] Sometimes [ ]
If so, what?_____

Able to motivate 200 feet without assistance? YES [ ] NO [ ] Sometimes [ ]

Able to motivate 1/4 mile without assistance? YES [ ] NO [ ] Sometimes [ ]

Able to motivate 3/4 mile without assistance? YES [ ] NO [ ] Sometimes [ ]

Able to climb three 12-inch steps without assistance? YES [ ] NO [ ] Sometimes [ ]

Able to wait outside without support for ten (10) minutes? YES [ ] NO [ ] Sometimes [ ]

If the person has a visual impairment:

Visual Acuity with best correction: Right Eye _____ Left Eye _____ Both Eyes_____

Visual Fields: Right Eye _____ Left Eye _____ Both Eyes_____

Does the applicant require a Personal Care Attendant when traveling? [ ] YES [ ] NO

If the person has a cognitive disability, is the person able to:

Give address and telephone numbers upon request? YES [ ] NO [ ]

Recognize a destination or landmark? YES [ ] NO [ ]

Deal with unexpected situations or unexpected changes in routine? YES [ ] NO [ ]

Ask for, understand and follow directions? YES [ ] NO [ ]

Safely and effectively enter and exit a transit vehicle? YES [ ] NO [ ]

Due to the disability indicated herein, I hereby certify that the above-named applicant is unable to utilize the fixed route bus service including mass transit facilities as effectively as persons who are not so affected, and to the best of my knowledge the above information is true and correct. In signing, I acknowledge that to the best of my knowledge, the information in this evaluation form is true and correct. Furthermore, I certify that I have medical information on file to document the above statements and will produce such documentation at the request of the Transportation Provider. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Professional's Name_____

Office Address_____

Office Phone_____ PA License#_____

Professional's Signature_____

If you have any questions concerning the above information, please contact:

GO Westmoreland
Scheduling Office
(724) 832 - 2706
Office Hours: Monday through Friday, 8:00 AM – 4:00 PM

ESCORT FORM

APPLICANT – PLEASE COMPLETE THE TOP PORTION OF THIS FORM

Date: _____

Name of applicant: _____
Last First MI

Address: _____
Street City State Zip

Do you require an escort when you travel? Yes _____ No _____

Do you require a wheelchair accessible vehicle? Yes _____ 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: _____

License No:_____

Physician's Signature: _____

When properly completed return to GO Westmoreland:

Email: info@westmorelandtransit.com

Fax: 724-853-2760