Westmoreland

Follow the arrow and GO!

41 Bell Way, Greensburg, PA 15601
1-800-242-2706

APPLYING FOR GO WESTMORELAND DISABILITY TRANSPORTATION SERVICES

GO Westmoreland will be utilizing the attached forms in determination of your eligibility for Disability Transportation Services.

The attached "REQUEST FOR CERTIFICATION OF ELIGIBILITY" is the application form that needs to be completed, either by the disabled individual, or by someone completing the form for him/her.

The second attached form is the "REQUEST FOR PROFESSIONAL VERIFICATION." This entire form needs to be completed by the physician that can verify that the person actually has the disability that is presented in the "REQUEST FOR CERTIFICATION OF ELIGIBILITY."

Once these forms have been completed and signed by the appropriate persons, the applications are returned to the GO Westmoreland office for review.

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.

If you are interested in participating in one of GO Westmoreland's Disability Transportation Services, please complete this form and send it with a copy of any additional documents to:

GO Westmoreland
41 Bell Way
Greensburg, PA 15601

- Once your application is received and reviewed you will be notified of your eligibility to participate.

- If you have questions about this program, this form or need this form in an alternate format please call:

1-800-242-2706

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: _____

Telephone: Home: _____ Cell: _____

County of Residence: _____ Date of Birth: _____

Social Security Number: _____

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
If YES, also please complete the attached "ESCORT FORM."

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: _____

Address: _____

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.

SIGNED: _____ DATE: ____/____/____

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

Name: _____ Phone: _____

Address: _____

SIGNED: _____ DATE: ____/____/____

In order to allow GO to evaluate your request, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please complete the following information and you may have your physician fill out and sign the Physician Authorization Form attached.

The following (please check one):
[ ] Physician
[ ] Health Care Professional
[ ] Rehabilitation Professional

is familiar with my disability and is authorized to provide information to GO Westmoreland required to complete this Certification.

Professional's Name: _____

Address: _____

_____

Phone: _____

Printed Name of Applicant: _____

Date of Birth of Applicant: _____

SIGNED: _____ DATE: ____/____/____
(Applicant's Signature)

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_____

Further comment: _____

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 [ ]

Does the applicant require a Personal Care Attendant when travelling? [ ] YES [ ] NO
If YES, also please complete the attached "ESCORT FORM."

Is there any other effect of the disability of which GO should be aware? Please specify: _____

_____

Professional's Name: _____

Office Address: _____

Office Phone: _____

SIGNATURE: _____ DATE: ____/____/____

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

GO Westmoreland
41 Bell Way
Greensburg, PA 15601
1-800-242-2706

Office Hours: Monday through Friday, 8:00 AM – 4:00 PM

Verification of Disability or Special Needs

GO Westmoreland
41 Bell Way
Greensburg, PA 15601
1-800-242-2706
724-853-2760 (fax)

Recipient Identification

Last Name:	First Name:	Initial:	Date of Birth:
SSN:		Phone #:	
Street Address:		Apartment #:	
City:	Municipality:	County: 65	State: Zip:
Emergency Contact:	Relationship:	Phone #:	

Recipient Release

The information provided in this application regarding your disability will be used to determine your eligibility for Transportation Services. Other information wilthin 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. Please print clearly.

Signature of Applicant _____ Date Signed _____

If the applicant is unable to sign this form (e.g. minor, disability, etc.) he/she may have someone sign and certify (below) on his/her behalf.

Signature of Designee _____ Date Signed _____ Relationship _____

Physician Certification

The individual named above has the following disability(ies.) Check all that apply.

☐ OVR ☐ SSI/SSDI ☐ Bureau of Blindness & Visual Services
☐ MH/MR ☐ United Cerebral Palsy (UCP) ☐ Registered Physical/Occupational Therapist

The individual named above receives, or is eligible for, disability services from these programs. Check all that apply.

☐ OVR ☐ SSI/SSDI ☐ Bureau of Blindness & Visual Services ☐ Center for Independent Living
☐ MH/MR ☐ United Cerebral Palsy (UCP) ☐ Registered Physical/Occupational Therapist ☐ Physician
☐ Registered Nurse ☐ PA Attendant Care ☐ Other

Limitations	These Limitations Apply				Status		
Indicate the tasks (below) related to using public transit that the individual listed above cannot do.	**Always**	**Usually**	**Occasionally**	**Rarely**	**Permanent**	**Temporary**	**If temporary, how long?**
Boarding vehicle without a wheelchair lift or ramp	☐	☐	☐	☐	☐	☐	
Recognizing a bus stop, identifying appropriate bus and route #	☐	☐	☐	☐	☐	☐	
Understanding/handling bus fare/money transactions	☐	☐	☐	☐	☐	☐	
Recognizing destinations if stops are announced	☐	☐	☐	☐	☐	☐	
Waiting for an hour	☐	☐	☐	☐	☐	☐	
Walking less than a 1/4 mile	☐	☐	☐	☐	☐	☐	
Communicating with people	☐	☐	☐	☐	☐	☐	
Understanding emergencies or handling emergencies well	☐	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	☐	

Does the individual lisrted above require a personal care attendant (for medical reasons)or escort for assistance while traveling ? ☐ Yes ☐ No

Explain:

Physician Signature

By signing, I affirm 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 GO Westmoreland.

Signature _____ Print or Type Name of Person Signing _____ PA License Number _____ Date _____

Office Street Address _____ City _____ State _____ Zip _____ Office Phone _____ Office FAX _____