Westmoreland

(724) 832 - 2706

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.

Once all forms are completed, they can be faxed to 724-853-2760 or mailed back to:

GO Westmoreland
41 Bell Way
Greensburg, PA 15601

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 and Zip Code _____

County of Residence _____ **Date of Birth** _____

Home Phone Number _____ **Cell Phone 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 Number _____

Relationship to Applicant _____

9. 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.

_____ _____

Signature of Applicant Date Signed

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

Name _____ Phone _____

Signature_____ Date_____

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

_____

(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.

Medical diagnosis of condition causing disability: _____

_____

Is this condition temporary? YES [NO [ ]

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

If the applicant has a disability effecting mobility, does the applicant:

Use 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 this applicant has a visual impairment:

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

If this applicant has a cognitive disability, is he/she 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."

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.

Print Name of Person Signing	Signature	PA License #	Date

Office Street Address	City, State, Zip	Phone Number

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

GO Westmoreland
41 Bell Way
Greensburg, PA 15601
(724) 832 - 2706
Office Hours: Monday through Friday, 8:00 AM - 4:00 PM

Verification of Disability or Special Needs

Westmoreland

Recipient Information

Last Name _____ **First Name** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Date of Birth _____ **Phone Number** _____

The individual named on the application 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

☐ MH/MR ☐ United Cerebral Palsy (UCP) ☐ Registered Physical/Occupational Therapist

☐ Registered Nurse ☐ PA Attendant Care ☐ Other

☐ Center for Independent Living ☐ Physician

Indicate the tasks (below) related to using public transit that the individual can't do.

Tasks	Always	Usually	Occ.	Rarely	Perm.	Temp.	If condition is temporary, how long will it last?
Boarding vehicle without wheelchair lift or ramp	☐	☐	☐	☐	☐	☐	
Recognizing a bus stop, identify apt bus and route#	☐	☐	☐	☐	☐	☐	
Understanding/handling bus fare/money transactions	☐	☐	☐	☐	☐	☐	
Recognizing destinations when stops are announced	☐	☐	☐	☐	☐	☐	
Waiting for an hour	☐	☐	☐	☐	☐	☐	
Walking less than a 1/4 mile	☐	☐	☐	☐	☐	☐	
Communicating with people	☐	☐	☐	☐	☐	☐	
Able to understand/handle emergency situations	☐	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	☐	

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

***Explain the medical reason for escort:**

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 Name _____ PA License Number _____ Date _____

Office Street Address _____ City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____