

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 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. 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.			
<input type="checkbox"/> OVR	<input type="checkbox"/> SSI/SSDI	<input type="checkbox"/> Bureau of Blindness & Visual Services	
<input type="checkbox"/> MH/MR	<input type="checkbox"/> United Cerebral Palsy (UCP)	<input type="checkbox"/> Registered Physical/Occupational Therapist	
The individual named above receives, or is eligible for, disability services from these programs. Check all that apply.			
<input type="checkbox"/> OVR	<input type="checkbox"/> SSI/SSDI	<input type="checkbox"/> Bureau of Blindness & Visual Services	<input type="checkbox"/> Center for Independent Living
<input type="checkbox"/> MH/MR	<input type="checkbox"/> United Cerebral Palsy (UCP)	<input type="checkbox"/> Registered Physical/Occupational Therapist	<input type="checkbox"/> Physician
<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> PA Attendant Care	<input type="checkbox"/> Other	

Page 2

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

Does the individual listed 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