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 your 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. Thank 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
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, PLEASE MAIL TO:

GO WESTMORELAND
41 BELL WAY
GREENSBURG, PA 15601