

**ADA Eligibility and Registration Form-page 1 of 4
Fayette Area Coordinated Transportation (FACT)**

For trips that could normally be made on a FACT fixed-route bus, you may be eligible for additional, paratransit service if you are a person with a disability.

◆ If you would like to participate in this special service, please complete this form and send it with a copy of the *Certification of Eligibility* form below to:

*Fayette Area Coordinated Transportation (FACT)
825 Airport Road
Lemont Furnace, PA 15456*

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

◆ If you have questions about this service, this form or need this form in an alternate format please call: 724/628-7433

Note: The information provided in this application regarding your disability will be used to determine your eligibility for special 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 and in analyzing the pilot project for future recommendations. Please print clearly.

PART 1: GENERAL

Last Name: _____ First Name: _____ MI...: _____

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

Telephone Home: _____ Work: _____ E-mail: _____

County of Residence: _____ Date of Birth: _____

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

___ 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". "...*a major life activity means* functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

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PART 2: WRITTEN VERIFICATION THAT YOU ARE A PERSON WITH A DISABILITY

Written verification by a knowledgeable organization or qualified individual that you are a person with a disability is required to participate in FACT's special services.

1. If you have written verification of a disability:

You may already have written verification that you are a person with a disability from a service organization by having an identification card, a written assessment of your disability, etc. If so, send a copy of this information to the transportation provider listed at the top of this form. If not, you will need to ask an organization or individual listed below to verify, in writing, that you are a person with a disability according to the ADA definition and then send it to the address listed at the top of page 1.

Please check the organization or individual whose written verification you are submitting with your application form.

- | | |
|--|--|
| <input type="checkbox"/> Office of Vocational Rehabilitation (OVR) | <input type="checkbox"/> Registered Physical/Occupational Therapist |
| <input type="checkbox"/> Social Security Insurance (SSI) and Disability Insurance (SSDI) | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Bureau of Blindness and Visual Services | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Center for Independent Living (CIL) | <input type="checkbox"/> PA Attendant Care Program |
| <input type="checkbox"/> Mental Health/Mental Retardation Program | <input type="checkbox"/> Community Services Program for Persons with Physical Disabilities |
| <input type="checkbox"/> United Cerebral Palsy | <input type="checkbox"/> Other: _____ |

2. If you do not have written verification of a disability:

Please fill out the **certification of disability form** below. It provides verification of a disability according to the definition in the Americans with Disabilities Act. This form can be used to acquire the necessary information for verifying a disability from a qualified health professional.

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PART 3: INFORMATION SO WE MAY SERVE YOU BETTER

1. Is your disability permanent? Yes No
 (A standard definition of a permanent disability is one that lasts for 12 months or longer.)

2. If not, how long is it expected to last? _____

3. What is the nature of your disability? Check those that apply.

- Mobility disability (please see question 4 below)
 Vision disability Mental disability
 Hearing disability Cognitive disability
 Other — Please specify: _____

4. Please check all mobility aids that apply.

- Manual wheelchair Crutches Cane
 Power Wheelchair Motorized Scooter Walker

5. Do you require the services of a personal care attendant or escort when you travel? (A personal care attendant or escort is a person that you need to assist you during the trip or at your origin or destination)

- Yes No Sometimes

Please describe when you need assistance: _____

6. Emergency Contact (Optional)

Name: _____

Relationship: _____

Phone (Home): _____ (Work): _____

7. Is there anything else you want us to know so we can serve you better?

- Yes No

If "Yes," please describe: _____

PART 4: RELEASE OF INFORMATION and YOUR CERTIFICATION OF THE APPLICATION FORM

I give my permission to _____ to contact a health care or other professional that I designate for additional information to verify that I am a person with a disability. Yes No

Your signature of that of the person who completed this form	Date

I understand that the purpose of this application is to determine if I am eligible to participate in FACT's special services. I certify that the information contained in this application is correct and truthful to the best of my knowledge.

Your signature of that of the person who completed this form	Date

Name of the person who completed this form _____ Relationship _____

**Certification of Disability Form
Americans with Disabilities Transportation page 4 of 4**

The purpose of this form is to provide written, independent verification that the applicant named below has a disability according to the definition in the Americans with Disabilities Act. This form is to be completed by a professional who is familiar with the applicant's disability. A professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services to people with disabilities. The applicant has applied for specialized transportation services from FACT. If you have any questions about this form, please call 724/628-7433.

Applicant Information (to be completed by applicant):

Last Name: _____ First Name: _____ MI: _____

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

Telephone Home: _____ Work: _____ E-mail: _____

County of Residence: _____ Date of Birth: _____

Applicant signature or that of the person who completed this form

Date

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". "...a major life activity means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

Please answer the following questions (**to be completed by the agency or person providing verification of eligibility information**)

Is the applicant's disability permanent? Yes No
(A standard definition of a permanent disability is one that lasts for 12 months or longer.) If not, how long is it expected to last? _____

What is the nature of the applicant's disability? Check those that apply.

Please check all mobility aids that apply.

- Mobility disability
- (please see question to the right)
- Vision disability
- Hearing disability
- Cognitive disability
- Mental disability
- Other _____

- Manual wheelchair Crutches
- Power Wheelchair Cane
- Motorized Scooter Walker

Signature of Professional Title Date

Name of Agency or Organization Telephone Address

Please send completed form to: **FACT, 825 Airport Rd, Lemont Furnace PA 15456**