WCTA Use Only
Card Number:_____
Expiration Date:____/_____/_____

WCTA ADA COMPLEMENTARY PARATRANSIT APPLICATION

Thank You for Your Interest in Applying for ADA Complementary Paratransit Service

Enclosed please find your application, once completed it will be utilized to determine your eligibility for ADA Complementary Paratransit service:

- ✓ Application Form (Pages 3-6), to be completed by the applicant or by someone completing the form for him/her.
- ✓ Voter Registration Information/Declination Form (Page 7-8), to be completed by the applicant even if you are already a registered voter or if you choose not to register to vote. *Due to the type of services provided, we are required to provide voter registration opportunities to age-eligible clients.
- ✓ Professional Verification Form (Pages 9-10), to be completed by a physician, professional organization or agency that can verify the applicant's disability that is presented in the application form.
- ✓ Personal Care Attendant (PCA) Certification Form (Page 11-12), to be completed by a physician, professional organization or agency to certify the need for a personal care attendant by the applicant. *This form is optional.
- ✓ Definition of Functional Impairments (Page 13-14), is provided for your information and contains a more detailed definition of those who may be eligible for this service.

Once these forms have been completed and signed by the appropriate persons, the applications are to be returned to WCTA for review to:

Washington County Transportation Authority, 50 East Chestnut Street, Washington, PA 15301
Fax - 724-223-9474
Phone – 724-223-8747

Once WCTA receives a properly completed application, an applicant will be certified within 21 days of the receipt of the application. The determination will be one of full eligibility, conditional eligibility, or denial of eligibility. If the application is approved, a passenger identification card will be issued. If an applicant feels they have been given an incorrect determination, they have the right to appeal such decision to WCTA. A copy of the WCTA Appeal process can be obtained by contacting WCTA at the contact information noted above.

WCTA ADA COMPLEMENTARY SERVICE
APPLICATION FORM

FULL NAME OF APPLICANT:	DATE:
ADDRESS:	
PHONE:	E-MAIL:
DATE OF BIRTH:	[ ] MALE [ ] FEMALE

Do you currently use WCT fixed route system (transit buses)? [YES] or [NO]
If no, what is the disability which prevents you from using our fixed route bus service?

Is this condition temporary? [YES] or [NO] If yes, expected duration until _____/_____/_____

How does this disability prevent you from using fixed route bus services? Please explain completely. Use additional sheets if needed.

Are there any other affects of your disability of which we need to be aware? [Yes] [No]
If yes, please explain -

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation.

Do you use any of the following aids for mobility? (Please check all that are applicable)

[ ] Manual Wheelchair	[ ] Electric Wheelchair	[ ] Powered Scooter
Make/Model of Wheelchair (if known) -		
[ ] Cane	[ ] Crutches	[ ] Walker
[ ] Guide Dog	[ ] Other (please specify) -	

Do you require a Personal Care Attendant (PCA) when you travel using transit? [Yes] or [No]
(If yes, also please complete the "Need for a PCA" Certification attached.)

Are you capable of mobility 200 feet without the assistance of another person?		
Yes	No	Sometimes

Are you capable of mobility ¼ mile without the assistance of another person?		
Yes	No	Sometimes

Are you capable of mobility 3/4 mile without the assistance of another person?		
Yes	No	Sometimes

Are you capable of mobility up three-12 inch steps without assistance?		
Yes	No	Sometimes

Can you wait outside without support for ten minutes?		
Yes	No	Sometimes

Contact information in the event of an Emergency:

Name:
Contact Phone:
Relationship to Applicant:

I hereby certify that I have reviewed and understand the ADA Paratransit Eligibility Rules and Regulations and that the information given in the Certification Application is true and correct to the best of my knowledge. I understand that falsifying any information may result in the termination of my ADA Paratransit Service.

Signature of Applicant:	Date: / /

If this application has been completed by someone other than the person requesting certification, that person must complete the following:

Name:		
Address:		
City:	State:	Zip:
Daytime Phone:		
Signature:	Date: / /	

***The information requested in this process will only be used for the provision of transportation service. Information obtained will only be shared with other transit providers to facilitate travel in those areas and will not be provided to any other person or agency.**

ALL APPLICANTS - PLEASE NOTE:

We are required to have all applicants complete the following **Voter Registration Information/Declination Form** and submit along with your application for ADA Complementary Paratransit Service. Your assistance in completing this form is appreciated.

VOTER REGISTRATION INFORMATION / DECLINATION FORM

NAME (please print):

Last *First* *M.I.*

ARE YOU REGISTERED TO VOTE? [YES] or [NO]

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE? [YES] or [NO]

*** IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Signature: Date:

- Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.
- If you apply to register to vote, the office at which you submit this registration application form will remain confidential.
- No information relating to a declination to register to vote will be used for any purpose other than for voter registration.
- If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.
- In order to be qualified to register to vote you must be at least 18 years of age on the day of the next election, you must have been a citizen of the United States for at least one month prior to the next election and have resided in Pennsylvania and the election district where you plan to vote for at least 30 days prior to the next election, and you must not have been confined to a penal institution for a conviction of a felony within the last five years.
- If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of the Commonwealth, Pennsylvania Department of State, 302 North Office building, Harrisburg, Pennsylvania 17120, or call the Department of State, toll-free, at 1-800-552-8683.

In order to evaluate your request, it is also necessary for a physician or other professional to confirm the information you have provided. Please have your physician or other professional who can verify your disability complete and sign the **Request for Professional Verification Form** attached.

REQUEST FOR PROFESSIONAL VERIFICATION FORM

RE: _____

(Applicant's Full Name)

Dear Physician / Professional:

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 requires that Washington City Transit provide ADA Complementary Paratransit Services to persons who, due to a disability, cannot utilize available fixed route bus 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 regarding this matter.

Capacity in which you know the applicant:

Medical Diagnosis of Condition Causing Disability:

Is this condition temporary? [YES] or [NO] If yes, expected duration until _____/_____/_____

If the person has a disability effecting Mobility, is the person:

Capable of mobility 200 feet without assistance?	[YES] or [NO] or [Sometimes]
Capable of mobility ¼ mile without assistance?	[YES] or [NO] or [Sometimes]
Capable of mobility ¾ mile unassisted?	[YES] or [NO] or [Sometimes]
Capable of mobility up three 12"steps unassisted?	[YES] or [NO] or [Sometimes]
Able to wait outside without support for 10 minutes?	[YES] or [NO] or [Sometimes]

Does this person use any mobility aids? If so, please specify -

Only complete if applicant has a visual impairment -

Visual Acuity with Best Correction -	Right Eye	Left Eye	Both Eyes
Visual Fields-	Right Eye	Left Eye	Both Eyes

REQUEST FOR PROFESSIONAL VERIFICATION FORM (Continued)

If the person has a cognitive disability, are they able to:

Provide addresses and telephone numbers upon request?	[YES] or [NO]
Recognize a destination or landmark?	[YES] or [NO]
Deal with an unexpected situation or unexpected change in routine?	[YES] or [NO]
Ask for, understand, and follow directions?	[YES] or [NO]
Safely and effectively travel through crowded and/or complex facilities?	[YES] or [NO]

Does the applicant require a Personal Care Attendant (PCA)?	[YES] or [NO]

***Please Note: If yes, please also complete the attached PCA Certification**

Is there any other affect of the disability that should be made known? Please specify:

Physician/Professional's Name (Please Print):
Office Address:
Office Phone:

Due to the disability indicated herein, I hereby certify that the above-named applicant is unable to utilize mass transit facilities and bus services as effectively as persons who are not so affected, and to the best of my knowledge the above information is true and correct.

Physician/Professional Signature:	Date:

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

Washington County Transportation Authority
50 E. Chestnut St.
Washington, PA 15301
www.washingtonrides.org
P: 724-223-8747
F: 724-223-9474

NEED FOR A PERSONAL CARE ATTENDANT (PCA) CERTIFICATION

This certification is for use by individuals who cannot travel without assistance and must have an attendant accompany them both on the vehicle and at their destination in order to be able to go about their business. **To be eligible, a person must have a physician or professional execute this form** to certify their disability and their need for such service. The service does not provide attendants but will allow eligible, certified riders needing such service to have their personal care attendant ride at no charge as long as the attendant boards and disembarks from the vehicle at the same time and location as the rider.

Name of Individual Requiring PCA:		
Street Address:		
City:	State:	Zip:
Daytime Phone:	E-Mail:	

Emergency contact other than applicant:

Name:	Phone:

Is the applicant confined to a wheelchair or utilizes other mobility devices?
Please specify:
Please explain the reason for the applicant's need for a PCA:

Authorizing Physician/Professional:

Printed Name:	Signature:	
Agency/Practice Name:		
Street Address:		
City:	State:	Zip:
Daytime Phone Number:		

DEFINITION OF FUNCTIONAL IMPAIRMENTS FOR ELIGIBILITY DETERMINATION

This Program is required by Section 5 of the Urban Mass Transportation Act of 1964, as Amended

1. The person cannot board or leave a transit vehicle with ease, reasonable speed, and/or without aid from another person. Standards 2 and 3 have to do with the person's walking and step climbing ability as it relates to the use of rapid transit systems, buses or trolleys. In order to meet either of these standards the person should have significant difficulty in:

   a. Climbing steps with risers 7 inches or more in height.

   b. Negotiating a long flight of stairs.

   c. Climbing from ground to first step on the transit vehicle, a distance of approximately 14 inches.

Examples of typical ailments which may qualify under these standards:

   a. Amputation of or anatomical deformity of foot or leg.

   b. Major restrictions in the movement of joints in hips, back, knee or ankle.

   c. Fracture of femur, tibia, tarsal bone or pelvis.

   d. Disorders of the nervous system resulting in moderate motor weakness in two extremities.

2. The person cannot stand without major support in a moving vehicle operating under normal vehicle acceleration and deceleration conditions. This standard is based on the person's inability to stand in a moving bus, trolley, train or subway car even with the aid (by holding with the hand) of a stanchion or overhead rail.

Examples of typical ailments which may qualify under this standard:

   a. Loss of balance due to inner-ear disorders.

   b. Disorders of the nervous system resulting in moderate motor weakness in two extremities.

   c. Disorders of the nervous system resulting in moderate lack of coordination of motor functions.

   d. Amputation of or major anatomical deformity of foot, leg, arm or hand.

   e. Fracture of femur, tibia, tarsal bone or pelvis.

3. Due to uncorrectable visual impairment the person cannot easily read transit vehicle identifications or identify transit stops. This standard automatically applies if the visual efficiency of the better eye after best correction is 20% or less. (The percent of remaining visual efficiency equals the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

4. Due to an uncorrectable hearing impairment; the person cannot hear verbal announcements or transit information through either direct personal or electronic communication. This standard applies if manifested by:

   a. Absence of air and bone conduction in both ears (auditory perception of not more than one pure tone at high volume will be considered as absence of air and bone construction); or

   b. No more than 40 percent discrimination for speech (ability to hear and understand no more than 40 out of 100 words of special test lists of words using a speech audiometer or hearing aid).

5. Due to physical or mental conditions the person cannot use public transit without the help of another person or special training.

The person's need for the aid of another person or training under this standard may be for physical aid and support or guidance. Organic brain syndrome, functional disorders, or mental deficiencies resulting in severe mental and social incapacity as evidenced by marked dependence upon others for personal needs or to avoid physical danger or the inability to understand the spoken word or the inability to follow simple directions would meet this standard. An IQ of 49 or less automatically qualifies the individual.

Special training includes formal or informal training to help the individual find transit stops or stations, to help in boarding the vehicle, to relieve unreasonable fears or anxieties or to reduce the probability of violence.

6. Due to physical or mental conditions, the person cannot travel to and from a regular bus stop to use public transit.