Application for Transportation Services

(MATP, Persons with Disabilities (PwD), ADA, Senior Shared Ride- 65+, Public Full Fare)

1. Transportation services may be available at a reduced rate, if you meet any of the following criteria:
   - You are currently on Medical Assistance through the Department of Human Services
   - You are a person with a disability between the ages of 18-64
   - You are a person who lives along a fixed route, but due to a disability cannot access it
   - You are aged 60 – 64 and live in a county serviced by CamTran
   - You are aged 65+

2. If you would like to apply, please complete the application for transportation services and send it with any copies of qualifying documents to the address below.

1226 N.Center St.

Ebensburg Pa, 16646

Attn:MATP

3. Applications are processed in the order in which they are received.

4. For ADA customers, we have 21 days to determine if you are eligible for services.

5. Incomplete or missing information or documents will delay processing.

6. Once processed, you will be notified by mail of the determination for your application.

If you have any questions or need this application in an alternate format, please call ***1-800-252-3883, TDD: PA RELAY 711.***

NOTE: The information provided in this application regarding your age, disability, and county of residence will be <u>used to determine your eligibility for shared ride transportation services</u>

<u>under various programs</u> including the Rural Transportation for Persons with Disabilities and Senior Shared Ride programs.

Other information within the form will be used for data collection purposes, to determine your eligibility for any additional transportation programs, and provide you with the appropriate referral service. This information is kept confidential and is used only by the professionals involved in evaluating your eligibility.

Please Print

Ecolane ID: _____

How did you first learn about CamTran's shared ride system?	
Hospital/Clinic Flyer	Saw a Bus
Friend/Family Member	Senior Center
Case Worker	Advertisement: (Publication)
Other: (Specify)	

GENERAL INFORMATION			
First Name:	Middle Name:	Last Name:	
Date of birth:	Age:	Email:	
Current address:			
City:	State:	Zip code:	
Home Phone:	Cell Phone:	County:	
Emergency Contact:	Relationship:	Phone #:	

AGE VERIFICATION: Please send a legible photo copy of one of the listed forms of proof of age along with this application.

A Medicare card is not an acceptable proof of age. Please check which verification you are enclosing.	
Armed forces discharge/separation papers	Pennsylvania ID card
Passport/naturalization papers	Photo motor vehicle driver's license
Baptismal certificate	Birth certificate (Maiden Name) _____
PACE ID Card	Resident Alien Card
Statement of age from U.S. Social Security Office	

ENVIRONMENT AROUND YOUR RESIDENCE
How many steps are there at the entrance you use at your residence?
Can you get to a vehicle without the help of another person? ___Yes ____ No
How would you describe the terrain where you live? ___ Steep ___ Hill ___ Paved Lane ___ Unpaved lane
Are there sidewalks in your neighborhood? ___Yes ___ No

NEEDS ASSESSMENT

What is your primary language?			
Do you have a medical assistance card? __ Yes __ No			
Do you have a disability according to the Americans w/ Disabilities Act (ADA)? If yes, attach the *Certification of Disability Form*			
Do you have any mobility devices such as…			
___ Manual Wheel Chair	___ Oxygen	___ Cane	
___ Motorized Scooter	___ Power Wheel Chair	___ Walker	
___ Crutches	___ Guide Dog	Other_____	
Do you require the services of a personal care assistant or escort when you travel? (Someone that is needed to assist you during the trip or at the origin or destination) ___ Yes ___ No ___ Sometimes			

MOBILITY FUNCTIONAL ASSESSMENT

For each below question, check ***one*** answer. Your answers should be based on: how you feel most of the time; under normal circumstances; using your mobility equipment; and whether you can perform this activity independently.

Without the help of someone else, can you:

Walk up and down three steps if there are handrails on both sides?	___Always	___Sometimes	___Never	___Unsure
Use the telephone to get information?	___Always	___Sometimes	___Never	___Unsure
Cross the street, if there are curb cuts?	___Always	___Sometimes	___Never	___Unsure
Ride up and down a wheelchair lift with handrails on both sides?	___Always	___Sometimes	___Never	___Unsure
Find your way to the bus stop, if someone shows you the way?	___Always	___Sometimes	___Never	___Unsure
Currently travel by yourself?	___Always	___Sometimes	___Never	___Unsure
Wait 10 minutes in good weather outdoors without a place to sit?	___Always	___Sometimes	___Never	___Unsure
Step on and off the curb from a sidewalk?	___Always	___Sometimes	___Never	___Unsure
Travel up or down a gradual hill on the sidewalk, in good weather?	___Always	___Sometimes	___Never	___Unsure
Travel 3 level blocks, on the sidewalk, when the weather is good?	___Always	___Sometimes	___Never	___Unsure
If you are able to do this, how long does it take you?	__< 5 min	__5 – 10 min	__ > 10	___Unsure
Have you ever gotten lost when traveling alone?	___Yes		___No	

If the weather is good and there are no barriers in the way, what is the farthest you can walk or travel outdoors on a level sidewalk, using your mobility aid? (Please select the box which most closely your answer)			
___ I cannot travel alone	___ Less than 1 block	___ 3 blocks	___ 6 blocks
___ Curb in front of house	___ 9 blocks	___ More than 9 blocks	Other_____
Have you ever received training to learn how to use the bus or travel around the community? ___Yes ___ No			
If yes, which agency or person provided the training? When were you trained?			
Did you successfully complete the training? ___Yes ___ No If no, why not?			
Was your training route specific? ___ Yes ___ No Which routes did you learn?			

Would you like to participate in training to learn to ride the bus? ___ Yes ___ No

CURRENT TRAVEL		
Do you currently use CamTran's **fixed route** bus services? __ Yes __ No ___ Sometimes		
Does the weather affect your ability to use CamTran fixed route bus service? Yes ___ No ___ If yes, please explain:		
List your most frequent destinations and how you get there now		
Destination address where you go	How often do you go there?	How do you get there?
1.		
2.		

DUPLICATION OF TRANSPORTATION SERVICES	
Do you currently receive any transportation services? ___ Yes ___ No	
Are any of your transportation costs paid for by another program or organization? (Select from below all that apply)	
Senior Citizens Shared Ride Transportation Program	Office of Vocational Rehabilitation (OVR)
Medical Assistance Transportation Program	Mental Health/Mental Rehabilitation (MH/IDD)
Americans w/Disabilities Act Complementary Paratransit	Area Agency on Aging
Group Home (Where you live)	Other_____

DEMOGRAPHIC INFORMATION The following information is not required for Shared Ride to sponsor 85% of your trip fare. This information is required by the Offices for Aging, Inc. for reporting purposes.

Ethnic Information:
White ___ African American___ Am Indian/Alaskan Native___ Asian American/Pacific Islander___ Hispanic Origin___

Do you live alone? ___Yes ____ No	Do you have adequate housing? ___Yes ____ No

INCOME AND HOUSEHOLD RELATED DATA

If you are NOT registered for the Medical Assistance Transportation Program (MATP), you may qualify, and this program could pay all of the cost for your eligible trips to medical appointments

After reviewing the chart below I think that…
____ I'm already registered with MATP _____ I may qualify for MATP _____I do not think I qualify for MATP

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
2025 POVERTY GUIDELINES

Household Size (select one)		**Annual Income (select one)**		
1	2	___ less than $15,650	___$15,651 - $21,150	___$21,151 - $26,650
3	4	___ $26,651 - $32,150	___$32,151 - $37,650	___$37,651 - $43,150
5	6	___ $43,151 - $48,650	___ $48,651-$54,150	
__ 7	__ 8	For families/households with more than 8 persons, add $5,500 for each additional person.		

MEDICAL ASSISTANCE INFORMATION (if applicable)	
Access Card # __ __ __ __ __ __ -__ __ __ __ __ __ __ __ __ __-__ __-__ __	
Recipient # __ __ __ __ __ __ __ __ __ __	Card Issue # ___ ___
Social Security Number # __ __ __-__ __-__ __ __ __	

Do you have a vehicle in the household?	__ Yes __ No Who owns the vehicle?
Do you receive any of the following services?	___ Methadone ___ Dialysis ___ STAP-Camp Name ___ After School Services ___ Other_____

PROFESSIONAL WRITTEN VERIFICATION OF DISABILITY

In order to be eligible based on a disability, the Certification of Disability and Request for Professional Verification must be completed by a qualified individual, familiar with your disability and from one of the organizations listed below.

Office of Vocational Rehabilitation (OVR)	*Bureau of Blindness and Visual Services*		*Registered Nurse*
Disability Insurance (SSDI)	*United Cerebral Palsy*	*PA Attendant Care Program*	*Physician*
Community Services Program for Persons with Physical Disabilities		*Registered Physical/Occupational Therapist*	
Mental Health/Mental Retardation Program (MH-MR)	*Center for Independent Living (CIL)*		*Other _____*

Information contained in this application will be kept confidential and shared only with professionals involved in evaluating your eligibility and appropriate CamTran personnel. CamTran staff may need to talk to the applicant later to get more information.

RELEASE OF INFORMATION and CERTIFICATION OF APPLICATION

I certify that the information contained in this application is correct and truthful to the best of my knowledge. I understand the purpose of this application is to determine if I am eligible to participate in transportation programs delivered by CamTran.

I give my permission to CamTran to contact a healthcare or other professionals that I designate for additional information to verify that I am a person with a disability. ___Yes ____ No

By signing below, I hereby agree to report any changes in circumstances immediately to this Service Provider regarding my eligibility for funding assistance. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services hearing. This affirmation statement covers this application and all attachments required for the determination of eligibility. I am authorizing that, in the event that the Service Provider must verify information regarding my trips from medical providers to which I am traveling, in order to comply with the PA Department of Human Services regulations, you have my permission to do so. The information will be held by only the Service Provider and its agents in the strictest confidence and will not be shared with any other agency, except the professionals from which we are receiving the information.

Your signature (or name person who completed this form) _____

Date:_____ Relationship:_____ Contact Number:_____

MAILING INSTRUCTIONS: Please check the following before mailing your application

___ Include a copy of ONE form of proof of age

___ Include a copy of any other important documents

___ Sign the Release of information and Certification of Application section

Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

Social Security Number or MA ID: _____

II. AUTHORIZATION. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("Authorized Party") to use or disclose the following:

Any medical-related information needed to verify my receipt of medical services for the purpose described below

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

Name: Insert Name of MATP ADMINISTRATORSusquehanna Regional Transportation Authority (dba. rabbittransit)

Address: Insert Contact Information for MATP ADMINISTRATOR901 N. Cameron Street, Harrisburg, Pa 17101

Phone: (____)____ - _____ Fax: (____)800 632 9063 717 848 ____ - 4853_____

E-Mail: _____info@rabbittransit.org

IV. PURPOSE. The reason for this authorization is:

To verify attendance to the appointment for medical services for which you received transportation through the Medical Assistance Transportation Program. **V. TERMINATION.** This authorization will terminate:

Upon sending a written revocation to the authorized party.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ **Being a Minor**. Patient is years old and considered a minor under state law.

☐ **Being Incapacitated**. Patient is incapacitated due to: _____

☐ **Other:** _____

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one) ☐ - **I consent** to have the above information released. ☐ - **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one) ☐ - **I consent** to have the above information released. ☐ - **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

Certification of Disability Form

Reduced Fare Transportation Services

Transportation for Persons with Disabilities (PwD) Program

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 transportation services under the Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by Central Pennsylvania Transportation Authority. If you have any questions about the form, please call 717-846-RIDE (7433) or toll free at 1-800-632-9063.

Applicant Information **to be completed by applicant (A completar por el solicitante)**:

Last Name: _____ First Name: _____ M.I.:_____

Address (Street & No.: _____

City: _____ State: _____ Zip Code: _____

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

_____

Applicant or Applicant Representative signature Date

Definition of Disability

Eligibility for this program is based on disability as defined by the Americans with Disabilities 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."

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

How many blocks can this person walked unassisted? (Circle One) <1 block 1-2 blocks 2-3 blocks 6 blocks 9 blocks

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.

_____ Mobility disability (please see question to the right)

_____ Vision disability

_____ Hearing disability

_____ Cognitive disability

_____ Mental disability

_____ Other — Please specify: _____

Please check all mobility aids that apply.

_____ Manual wheelchair _____ Crutches

_____ Power Wheelchair _____ Cane

_____ Motorized Scooter _____ Walker

_____ Guide/Service Dog _____ White Cane

_____ Personal Care Assistant (nurse, aide, etc.)

_____

Signature of Professional Date

_____

Title Name of Agency or Organization

Address Telephone

Please send completed form to:
CamTran
1226 N. Center St. Ebensburg Pa,
16646

REQUEST FOR PROFESSIONAL VERIFICATION

Dear Dr. ----------

The attached authorization has been submitted by _____ who has indicated that you can provide information regarding his/her disability and its impact on his/her ability to utilize our transit services. Federal law requires that the Cambria County Transit Authority 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

Must provide a <u>medical diagnosis</u> of condition causing disability to process this application:

_____

_____

Is the condition temporary? Yes [ ] No [ ] Expected duration until _____/ _____/ _____.

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

Able to walk 200 feet without assistance? Yes [ ] No [ ]
Sometimes ----------

Able to walk 1 / 4 mile without assistance? Yes [ ] No [ ]
Sometimes ----------

Able to walk 3 / 4 mile without assistance7 Yes [ ] No [ ]
Sometimes ----------

Able to climb three 12-inch steps without assistance? Yes [ ] No [ ]
Sometimes ----------

Able to wait outside without support for 10 minutes? Yes [ ] No [ ]
Sometimes ----------

Does this person use any mobility aids? _____ If so, what? _____

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 [ ]

If the person has a cognitive disability, is the person able to:

Give addresses 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 travel through crowded and/or complex facilities?
Yes [ ] No [ ]

Is there any other effect of the disability of which the Cambria County Transit Authority should be aware Please describe:

Physician/Office Name :

Office Address:

Office Phone:

Physician Signature: _____

Please Return As Soon As Possible To: Cambria

County Transit Authority

1226 N. Center St.
Ebensburg, Pa 15931

Phone: 800-252-3889
Fax: 814-471-6820

CamTran

February 12, 2025

Dear Paratransit Applicant:

Enclosed you will find a voter registration form and a declination form for voter registration. New Pennsylvania regulations require that when an ADA Paratransit application is mailed out, it must be accompanied by the voter registration information.

If you would like to register to vote, please complete the enclosed form. If you are not interested in registering to vote, please complete the declination form. If you need assistance with any of the voter registration information, or the paratransit application, please call ***1-800-252-3883, TDD: PA RELAY 711.***

DECLINATION FORM

NAME (Please Print Last Name, First, M.I.)

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW, WOULD YOU LIKE TO APPLY TO REGISTER TO VOTE HERE TODAY?

☐ Yes

☐ No OR ☐ No, I am already registered to vote where I live now.

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

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 personnel at 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 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 vote, you must be 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 privacy in deciding whether to register 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 1-800552-8683.**

_____ _____

(Signature) (Date)