

Certification of Disability Form

Reduced Fare Transportation Services
Rural Transportation for Persons with Disabilities (PwD) Program
Americans with Disabilities Act (ADA) Program

The purpose of this form is to provide written, independent verification that the applicant named below has a disability in accordance with 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 Rural Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by STEP Transportation. If you have any questions about the form, please call:

STEP Transportation | 570-323-7575 or 800-222-2468

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

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

Phone (Home): _____ Phone (Work): _____ Email: _____

Signature of applicant 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". "...major life activities mean functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work."

Is the applicant's disability permanent? YES NO

(A standard definition of permanent disability is one that lasts for 12 months or longer)

If "no", how long is the disability expected to last?

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

Vision disability Hearing disability Cognitive disability Mental disability

Physical disability Other (Please specify)

Signature of Professional

Date

Title

Name of Agency or Organization

Address

Telephone

Please check all mobility aids the applicant uses:

Manual wheelchair Power wheelchair Motorized scooter

Walker Cane Crutches