Certification of Disability Form

Reduced Fare Transportation Services

Rural 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 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

Lycoming County: (570) 323-7575 or (1-800) 222-2468

Clinton County: (1-800) 206-3006

Last Name: _____ First Name: _____ Initial: ____ Date of Birth: _____

Address (Street & No.) _____

City: _____ State: **PA** 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 applicants' disability permanent? (A standard definition of permanent disability is 12 months or longer) _____

If not, how long is your disability expected to last? _____

What is the nature of the applicants' disability? Check all that apply:

Vision Disability ____ Hearing Disability ____ Cognitive Disability ____ Mental Disability ____

Physical Disability ____ Specify) _____

Please check all mobility aids the applicant uses:

Manual Wheelchair ____ Power Wheelchair ____ Motorized Scooter ____

Walker ____ Cain ____ Crutches ____

_____

Signature of Professional Date

_____

Title Name of Agency or Organization

_____

Address Telephone