



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 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 Rural Transportation for Persons with Disabilities (PwD) program, which is being administered by the Pennsylvania Department of Transportation with services provided by the EMTA you have any questions about the form, please call **570-888-7330 or 1-800-242-3484.**

Applicant Information (to be completed by applicant):

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

Address (Street & No.): _____

City: _____ State: _____ Zip Code: _____

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

 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". "...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)

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.

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Mobility disability (please see question to the right) | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Vision disability | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Hearing disability | <input type="checkbox"/> Motorized Scooter | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Cognitive disability | | |
| <input type="checkbox"/> Mental disability | | |
| <input type="checkbox"/> Other — Please specify: _____ | | |

 Signature of Professional

 Date

 Title

 Name of Agency or Organization

 Address

 Telephone

Please send completed form to: **27824 ROUTE 220 ATHENS, PA 18810**