



FOR OFFICE USE ONLY:

Code: _____

___ Emailed CATA Staff

___ Emailed Ride Right

APPLICATION FOR PERSONS WITH DISABILITIES ELIGIBLE UNDER THE AMERICANS WITH DISABILITIES ACT (ADA)

Eligibility for reduced fares on CATARIDE, which provides curb-to-curb transportation within the area served by the CATABUS public bus system, is limited to persons age 65 and over and to persons whose disabilities prevent their use of the CATABUS system.

This application is to be completed by persons whose disabilities prevent them from boarding a bus or navigating the CATABUS public bus system without assistance (beyond assistance from the driver to board via a lift/ramp and to secure a mobility device) or have specific conditions related to a disability which prevent travel to and from bus stops. If you can utilize the CATABUS system some of the time or your disability is temporary, you may be approved only for certain trips or until you are again able to use the bus system. **If you are age 65 or over, please complete the CATARIDE application for Persons Age 65 and Over Not Eligible Under ADA.**

Upon CATA's acceptance of this application you will be provided with a brochure outlining program conditions and regulations. Your utilization of reduced CATARIDE fare will be deemed an acceptance of the terms contained therein. Please return this completed application to CATA via mail (CATA, 2081 W. Whitehall Road, State College, PA 16801), fax (238-7643), or email (catarideapp@catabus.com). You will be notified of eligibility determination within 21 days from receipt of all completed application materials, which include physician verification and any additional required information.

Please notify CATA if at any time the information and conditions submitted on this form change.

Name: _____ Gender (M/F): _____
(Last) (First) (Middle)

Address: _____
(Street) (Apt. #) (City) (State) (Zip)

Birth Date: ___/___/___ Telephone: (____) _____ Email: _____

I hereby certify that the following information is true and correct to the best of my knowledge.

Signature: _____ Date: ___/___/___

Disability: _____

(-continued-)

SECTION I.

My disability is Permanent Temporary until ___/___/___

I use a mobility aid (wheelchair, walker, braces, cane, etc.): No Yes

If "Yes," please specify: _____

I can use a bus with a lift and/or ramp on my own: No Yes

If "No," please indicate why not: _____

It is impossible for me to use buses Anytime Sometimes because: _____

If you are able to use buses "Sometimes," please list the specific conditions under which you can do so (attach an additional sheet if necessary): _____

SECTION II.

I will require a personal care attendant (PCA) when I travel on CATARIDE vehicles because I regularly use an attendant to assist with daily living: No Yes Sometimes

If "Yes" or "Sometimes," please indicate why and/or under what conditions you require a PCA:

SECTION III.

The physician/health care professional named below is familiar with my disability, and is authorized to provide information to CATA to complete eligibility requirements.

Applicant Signature: _____ Date: ___/___/___

Physician/Health Care Professional: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

FOR OFFICE USE ONLY:

Physician Verification? Yes No By: _____ Date: ___/___/___

ID Shown: _____ ID #: _____

Approved / Denied by: _____ Date: ___/___/___

Pass # Issued: _____ (65 or Over/Under 65)

Replacement? Yes No Replaces #: _____