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 **CATA**RIDE, which provides origin-to-destination transportation within the area served by the **CATA**BUS public bus system, is limited to persons age 65 and over and to persons whose disabilities prevent their use of the **CATA**BUS system.

This application is to be completed by persons whose disabilities prevent them from boarding a bus or navigating the **CATA**BUS 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 **CATA**BUS 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 CATA**RIDE **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 ((814) 238-2867), 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. If the Authority is unable to do so within the 21 days, on the 22nd day after receipt of all completed application materials, individuals will be provided service as if the application has been approved. Service may be terminated only if and when the Authority denies the application. Written letters of approval and denial are issued for all applications. If your application is denied, the determination shall state the reasons for the finding and you will be provided with CATA's **CATA**RIDE Paratransit Service Appeal Process.

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: _____

Township: _____

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 **CATA**RIDE 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 #:_____