# ACCESS CONNECTIONS PROGRAM – APPLICATION

Name: _____
Last First Date of Birth
Address:_____

City_____ State_____ Zip_____

Phone**:** Home _____ Work_____

Cell_____ E-mail address_____

**Information about your disability**

- What is your disability?_____
- How does your disability limit you? Check all that apply:

  _____ Walking _____ Seeing _____ Communicating

  _____ Understanding _____ Hearing _____ Problem solving

- Is your disability permanent? _____Yes _____No
- If no – what is the expected duration? _____
- Do you use any mobility aids? _____No _____ Yes (If yes, check all that apply):

  _____Manual wheelchair _____ Scooter _____White Cane

  _____Motorized wheelchair _____Crutches _____ Service animal

  _____Walker or rollator _____Portable oxygen _____ Other _____

**Check the documentation you are submitting with the application:**

Verification of disability (including diagnosis) from:

_____Health care provider _____ School district (IEP) **must include signature page*

_____Agency from which you receive disability related services

Proof of Age (Documents must be valid and not expired):

_____ PA Driver's license _____ Birth Certificate _____ Military Discharge

_____ PA Photo ID _____ PACE Card _____ Social Security Verification

_____ Passport _____ Immigration / Naturalization Papers

I am currently eligible for Medical Assistance or Community Health Choices (check one)

_____ Yes _____ No _____ Not Sure

**Port Authority Bus Service You Will Use**

- Which Port Authority routes serve your neighborhood? _____
- Where is the bus stop closest to your home? _____
- Why do you need ACCESS Connections Service? (Check as many as apply)

  _____ The bus stop is more than ¾ mile from my home

  _____ The bus stop is more than ¾ mile from my destination

  _____ There is no bus service at the time I need to travel

  _____ I have to take several buses, which takes me a long time

## Trips you will take

Please list the three most common trips you would like to take.

| Origin (Address) | Destination (Address) | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

**Emergency Contact**

- Please provide the name and phone number for someone we should contact in case of an emergency (optional):

_____

**Will you need future materials in an accessible format? (Circle):**

Large Print Word or Txt file by e-mail Audio Cassette Braille

**Signature (Required)**

I certify that I have been truthful and that the information I have provided is accurate and correct.

_____ _____

Signature Date

Submit your completed application along with proof of age and verification of your disability. Mail to ACCESS Connections Program, 650 Smithfield St., Pittsburgh, PA 15222 or e-mail to ada@accesstransys.com