

## Certification of Disability Form

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 or does cognitive assessments for people with disabilities. The applicant has applied for transportation services, which are being administered by the Pennsylvania Department of Transportation with services provided by the LIFT. If you have any questions about the form, please call 814-455-3330.

### 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 mean functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and work".

Please answer the following questions (to be completed by the 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:

\_\_\_\_ Mobility disability (please see question to the right)

\_\_\_\_ Manual wheelchair    \_\_\_\_ Crutches

\_\_\_\_ Vision disability

\_\_\_\_ Power wheelchair    \_\_\_\_ Cane

\_\_\_\_ Hearing disability

\_\_\_\_ Motorized Scooter    \_\_\_\_ Walker

\_\_\_\_ Cognitive disability

\_\_\_\_ Mental disability

\_\_\_\_ Other – Please specify: \_\_\_\_\_

Signature of Professional

Date

Title

Name of Organization

Address

Telephone

**Please send completed form to The LIFT @ 127 East 14<sup>th</sup> Street \* Erie \* PA \* 16503 \* or fax to 814-455-3530**