

# LIFT Senior Citizen Program

## Part A TO BE COMPLETED BY CUSTOMER

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY/ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_  
EMERGENCY ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
Are you able to use the EMTA bus? \_\_\_\_\_ Yes \_\_\_\_\_ no  
Do you use any of the following equipment: \_\_\_\_\_ cane \_\_\_\_\_ crutches \_\_\_\_\_ walker  
\_\_\_\_\_ wheelchair: If yes, can you transfer with minimal assistance? \_\_\_\_\_  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_

**Please note:** Our wheelchair ramps have a loading capacity of 600 lbs, including the wheelchair, and are 28 ½ inches wide by 48 inches long with a door height of 5 feet.

**If you live within ¼ mile of a bus route this application MUST be signed in Part B by your physician or a Social Service Agency to qualify for LIFT services.**

## Part B TO BE COMPLETED BY PHYSICIAN OR SOCIAL SERVICE AGENCY

If the customer cannot use a EMTA bus, please provide a description of the functional disability and the extent of the disability ***in non-clinical terms***:

Is this disability temporary? \_\_\_\_\_ Does the customer require an escort? \_\_\_\_\_

*I certify that, to the best of my knowledge, the above named person's functional disability, as stated above, requires paratransit transportation.*

Name (Sign) \_\_\_\_\_ (Print) \_\_\_\_\_  
Date \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

## Part C TO BE COMPLETED BY PHYSICIAN OR SOCIAL SERVICE AGENCY

RECIPIENT # \_\_\_\_\_ CARD ISSUE # \_\_\_\_\_

OTHER ELIGIBLE HOUSEHOLD MEMBERS:

NAME	RECIP #	SSN	DOB

You may attach a separate sheet if necessary

**Part D TO BE SIGNED BY ALL APPLICANTS**

\*\*\*\*This application cannot be processed unless signed and dated. If you fail to sign this application it will be returned to you.

**Affirmation of Information:**

***I hereby certify, that, to the best of my knowledge, the information contained herein is true, correct and complete. I agree to report any changes in circumstances immediately to this Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Public Welfare fair hearing. This affirmation statement covers all attachments required for the determination of eligibility.***

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

How did you hear about the LIFT? \_\_\_\_\_ Radio \_\_\_\_\_ TV \_\_\_\_\_ newspaper  
\_\_\_\_\_ friend \_\_\_\_\_ other (please specify) \_\_\_\_\_

**FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE**

**ELIGIBILITY INFORMATION FOR MATP**

DATE OF SERVICE: \_\_\_\_\_

HEALTH BENEFIT CODE: \_\_\_\_\_

CATEGORY OF ASSISTANCE: \_\_\_\_\_

PROGRAM STATUS CODE: \_\_\_\_\_

MATP FUNDING STATUS: GROUP I \_\_\_\_\_ GROUP II \_\_\_\_\_

**GROUP II = D-00, D-05, B-00, PD-00, PD-21, PD-22, PD-29, TB-00, TD-00, TD-11**

**APPLICATION PROCESSING INFORMATION**

AUTHORIZED SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

FUNDING RECEIVED: \_\_\_\_\_