Application for MATP Services

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	10 Digit Recipient #:	Card Issue #:	Phone #:
Street Address:			Apt. #:
City:	Municipality:	County:	State/Zip Code:
Name of Emergency Contact:	Relationship:	Emergency Contact's Phone #:	

Do you live in a nursing home?	☐ Yes	☐ No	☐ I don't know
Do you live in a personal care home?	☐ Yes	☐ No	☐ I don't know
Does the personal care home receive an agreement to provide transportation services for you?	☐ Yes	☐ No	☐ I don't know

MATP Funding Status (Completed by Office Personnel) ☐ **Group I** ☐ **Group II**

List Other Eligible Household Members Below:

Name	DOB	Recipient #	Card Issue #	SSN	Mode	Frequency Wk - Mo	Status
					(Completed by Office Personnel)		

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 the 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 if benefits are denied. This affirmation statement covers all attachments required for the determination of eligibility.

Signature of Client or Designee _____ Date _____

FOR OFFICE USE ONLY

Applicant Determined Eligible: ☐ Yes ☐ No (If not please state reason for ineligibility below)	Date of Initial Eligibility:	Date Client Notified:
Reason for Ineligibility:	Signature of Interviewer:	Date Signed:

Application for MATP Services
Assessment of Need

General Transportation Information

1. How did you hear about MATP?		
2. How many adults in the household?		
3. Do you have a valid driver's license? (If no skip to #7)	☐ Yes	☐ No
4. Do you have a vehicle that is legally registered, insured, and drivable? If the vehicle is not available, explain why. (If yes skip to #6 – If no skip to #5)	☐ Yes	☐ No
5. Do you have access to a vehicle belonging to a friend or other family member? (If yes, skip to #11, automatically mileage – If no skip to #7)	☐ Yes	☐ No
6. Are you able to take yourself (and/or children) to medical appointments? (If yes, skip to #11, automatically mileage)	☐ Yes	☐ No
7. Do you have a relative or friend who is willing to take you to medical appointments? If so, locally? Out of town? (If yes, automatically mileage – If no go on to #8)	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
8. If the person(s) applying do not have a vehicle, access to a vehicle, or a friend/relative willing to provide transportation – how are you/they getting to other appointments or shopping now?		
9. If you/they do not have a vehicle, etc. – is the public transit service available?	☐ Yes	☐ No
10. If on a public transit route, is it adequate to meet the need?	☐ Yes	☐ No
11. Is the person or, in case of a family, more than one adult working?	☐ Yes	☐ No
12. If yes, what hours does the person(s) work?		

Application for MATP Services
Assessment of Need

Complete for <u>each</u> MATP recipient listed on Application Page 1

Last Name:	First Name:	Middle Initial:	Social Security #:
10 Digit Recipient #	Card Issue #:	**MATP Funding Status (Completed by Office Personnel)** ☐ Group I ☐ Group II	
Name of Emergency Contact:	Relationship:	Emergency Contact's Phone #:	
Do you live in a nursing home?		☐ Yes ☐ No ☐ I don't know	
Do you live in a personal care home?		☐ Yes ☐ No ☐ I don't know	
Does the personal care home receive an agreement to provide transportation services for you?		☐ Yes ☐ No ☐ I don't know	

Transportation Frequency (this information is needed to determine the frequency of ongoing transportation needed)

List known locations for medical services needed	Approx. Distance from home	# of weeks per month	Check the days of week transportation is needed to this location							Appt Time if known
			Mon	Tues	Wed	Thur	Fri	Sat	Sun	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	

Transportation Modes	Are there medical reasons why you cannot use this mode
Fixed routs (If available)	☐ Yes ☐ No
Paratransit Services (If available)	☐ Yes ☐ No
Taxis (If available)	☐ Yes ☐ No
Do you live ¼ mile or less from bus route services?	☐ Yes ☐ No

If there are medical reasons why you cannot use the above transportation modes, we need a "Verification of Disability and Special Needs" form completed by your medical provider.

Application for MATP Services
Assessment of Need

Complete for each MATP recipient listed on Application Page 1

Limitations and Disabilities

Can you speak and understand English?	☐ Yes ☐ No	
If not, what language do you speak?		
Will you be traveling with a Personal Attendant or Escort?	☐ Yes ☐ No	**If Yes and the recipient is not a child, we need a "Verification of Disability and Special Needs" form completed by your medical provider.**
Do you have a disability that requires special accommodation?	☐ Yes ☐ No	**If Yes, we need a "Verification of Disability and Special Needs" form completed by your medical provider.**

Nature of Disability	Check all that apply	Use of Mobility Aid	Check if you use this mobility aid	Is the use of this aid temporary?	Date temporary need will end	Comments and Descriptions
Mobility Disability	☐	Manual Wheelchair	☐	☐ Yes ☐ No		
Hearing Disability	☐	Motorized Wheelchair	☐	☐ Yes ☐ No		
Visual Disability	☐	Scooter	☐	☐ Yes ☐ No		
Cognitive Disability	☐	Oversized Wheelchair	☐	☐ Yes ☐ No		
Behavioral Health Disability	☐	Walker	☐	☐ Yes ☐ No		
Gross Obesity	☐	Crutches	☐	☐ Yes ☐ No		
Other	☐	Braces	☐	☐ Yes ☐ No		
		Service Animal	☐	☐ Yes ☐ No		
		Other (Describe)	☐	☐ Yes ☐ No		

Is your wheelchair greater than 30" in width and 48" in length (measured 2 in. above the ground) and weigh no more than 600 lbs when occupied? ☐ Yes ☐ No ☐ Not Applicable

Can you transfer to a seat? ☐ Yes ☐ No

Do you need assistance to transfer to a seat? ☐ Yes ☐ No

Application for MATP Services
Verification of Disability or Special Needs

(Page 1 of 2)

Complete for each MATP recipient listed on Application Page 1

Applicant Section

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	10 Digit Recipient #:	Card Issue #:	Phone #:
Street Address:			Apt. #:
City:	Municipality:	County:	State/Zip Code:

Applicant Release Section

I understand that the purpose of this evaluation is to help in determine the most cost effective and appropriate mode of transportation for me. I understand that the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby authorize my medical representative to release any and all information required by the Medical Assistance Transportation Program regarding my medical condition, for the purpose of determining an appropriate method of transporting me to medical services.

Applicant Signature Date

If applicant is unable to sign this form he/she may have someone sign and certify (below) on applicant's behalf (e.g., minor, disability)

Signature of Person Signing for Applicant	Date	Print Name	Relationship to Applicant

Certification Section

The individual named above has the following disability(ies.) Check all that apply.

☐ Mobility	☐ Vision	☐ Hearing
☐ Cognitive	☐ Behavioral	☐ Other

Application for MATP Services
Verification of Disability or Special Needs

(Page 2 of 2)

Complete for <u>each</u> MATP recipient listed on Application Page 1

Limitation Section

Indicate the tasks (below) related to using public transit that the individual listed above cannot do.	These limitations apply				Status		
	Always	Usually	Occasionally	Rarely	Permanent	Temporary	If so, how long?
Boarding vehicle without a wheelchair lift or ramp	☐	☐	☐	☐	☐	☐	
Recognizing a bus stop, identifying appropriate bus and route #	☐	☐	☐	☐	☐	☐	
Understanding/handling bus fare/money transactions	☐	☐	☐	☐	☐	☐	
Recognizing destinations if stops are announced	☐	☐	☐	☐	☐	☐	
Waiting for an hour	☐	☐	☐	☐	☐	☐	
Walking less than a 1/4 mile	☐	☐	☐	☐	☐	☐	
Communicating with people	☐	☐	☐	☐	☐	☐	
Understanding emergencies or handling emergencies well	☐	☐	☐	☐	☐	☐	
Other (describe):	☐	☐	☐	☐	☐	☐	
Does the individual require a personal care attendant or escort for assistance while traveling	☐ Yes	☐ No					

Certification Section

The individual named above receives or is eligible for disability services from these programs. Check all that apply.

☐ OVR	☐ SSI/SSDI	☐ Bureau of Blindness & Visual Services	☐ Center for Independent Living
☐ MH/MR	☐ United Cerebral Palsy (UCP)	☐ Registered Physical/Occupational Therapist	☐ Physician
☐ Registered Nurse	☐ PA Attendant Care	☐ Other	

Verification Section

By signing, I affirm that to the best of my knowledge, the information in this evaluation form is true and correct. Furthermore, I certify that I have medical information on file to document the above statements and will produce such documentation at the request of the Medical Assistance Transportation Program Provider. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Print or Type Name of Person Signing	Signature	Pennsylvania License # (if applicable)	Date
Office Street Address, city, state & zip		Office Phone #	Office Fax #