

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: _____