MATP REGISTRATION - Application Assessment

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance Transportation Program

Recipient Identification

Last Name:		First Name:		Initial:	Date of Birth:
SSN:	MA Recipient #:			Phone #:	
Street Address:				Apartment #:	
City:	Municipality:		County:	State:	Zip:
Emergency Contact:		Relationship:		Phone #:	

General Transportation Assessment

Do you speak English? ☐ Yes ☐ No If no, what language do you speak?

Do you have a valid Driver's Licens ☐ Yes ☐ No Do you have a vehicle that is legally registered, insured, and drivable? ☐ Yes ☐ No

Are you or another household member able to drive you (and/or other household members) to medical appointments? ☐ Yes ☐ No

If you checked "No" - Please explain below. (Supporting documentation will be required.)

Do you have access to a vehicle of a friend or relative? ☐ Yes ☐ No Will your friend or relative take you to medical appointments? ☐ Yes ☐ No If yes, local? ☐ Yes ☐ No Out of town? ☐ Yes ☐ No

If yes, name and address of friend or relative with vehicle.

If you do not have a vehicle or access to a vehicle, how do you get to other appointments, shopping, or other personal needs? Describe below.

Do you live in a nursing home? ☐ Yes ☐ No Do you live in a personal care home? ☐ Yes ☐ No If yes, does your care agreement include transportation? ☐ Yes ☐ No

Do you live 1/4 mile or less from a bus route? ☐ Yes ☐ No ☐ I don't know

Do you need an escort to assist with your transportation? ☐ Yes ☐ No Will you need to travel with an interpreter? ☐ Yes ☐ No

Do you have a disability that requires special accommodation? ☐ Yes ☐ No

Are there medical reasons why you cannot use any of the following transportation modes? Fixed Route? ☐ Yes ☐ No Paratransit Service? ☐ Yes ☐ No Taxi? ☐ Yes ☐ No

Assessment of Recurring Appointments

List known locations for needed medical services.	Estimated distance from home	Number of weeks per month	Check the days of the week transportation is needed.							Appointment times if known	Comments
			Mon.	Tue.	Wed.	Thu.	Fri.	Sat.	Sun.		
			■	■	■	■	■	■	■		
			■	■	■	■	■	■	■		
			■	■	■	■	■	■	■		
			■	■	■	■	■	■	■		
			■	■	■	■	■	■	■		
			■	■	■	■	■	■	■		

Mobility Assessment

Nature of Disability (Check all that apply)	Use of Mobility Aid (Check all that apply)	Is the use of this mobility aid temporary?	If temporary, date need will end	Comments and Descriptions
☐ Mobility Disability	☐ Manual Wheelchair	☐ Yes ☐ No		
☐ Hearing Disability	☐ Motorized Wheelchair	☐ Yes ☐ No		
☐ Visual Disability	☐ Scooter	☐ Yes ☐ No		
☐ Cognative Disability	☐ Oversized Wheelchair	☐ Yes ☐ No		
☐ Behaviorial Health	☐ 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, 48" in length, measured 2 inches above the ground? Does your wheelchair weigh no more than 600 pounds 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

Signature

I understand the purpose of this evaluation is to help determine the most cost effective and appropriate mode of transportation for me. I understand that the information about any disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby certify, 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 MATP Service Provider. I understand documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services fair hearing if benefits are denied. This affirmation statement covers all attachments required for the determination of eligibility.

Signature of Applicant or Designee

Date Signed

FOR OFFICE USE ONLY			
Eligible: ☐ Yes ☐ No	Eligibility Date:	Recipient Notified: ☐ Yes ☐ No	Date Notified:
Application: ☐ Sent ☐ In-person	Date Application Sent:	Date Application Returned:	Received By:
Assigned Transportation Mode: ☐ Fixed Route ☐ Mileage Reimbursement ☐ DOT Shared Ride ☐ Contracted Volunteer Driver ☐ Paratransit			
MATP Funding Status: ☐ Group I ☐ Group II			
Notes:			

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 *e-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* means functions such as caring for one's self, 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.

_____ Mobility disability (please see question to the right)
_____ Vision disability
_____ Hearing disability
_____ Cognitive disability
_____ Mental disability
_____ Other — Please specify: _____

Please check all mobility aids that apply.

_____ Manual wheelchair _____ Crutches
_____ Power Wheelchair _____ Cane
_____ Motorized Scooter _____ Walker

_____
Signature of Professional Date

_____
Title Name of Organization

_____
Address Telephone

Please send completed form to: ***e-LIFT 127 E 14TH St. • Erie • 16503 or Fax 814-455-3530***