LIFT Application Instructions
For Senior Citizen Program

QUESTIONS? CALL 455-3330

This application cannot be processed unless it is completed in full.

Part A: This section is to be completed by all applicants.

Part B: This section is to be filled out by a physician or social service agency if the applicant lives within ¼ mile of a bus route and/or if he/she needs an escort.

Part C: This section only needs to be completed if the applicant receives MEDICAID.

Part D: This section **must** be signed by all applicants.

*Applicants 65 years or older must attach a copy of one of the following forms.*

**PENNDOT approved age verification:**

A. Birth Certificate  
B. Baptismal Certificate  
C. Drivers License  
D. Passport  
E. PACE Card  
F. Naturalization Papers  
G. Armed Forces Discharge Papers  
H. Social Security Statement of Benefits *with birthdate*  
I. PENNDOT Non-Drivers License  
J. Veteran’s Universal Access ID Card

SEND THE COMPLETED APPLICATION TO:

EMTA/LIFT  
127 E 14TH ST  
Erie, PA 16503
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 ONLY BY MEDICAID RECIPIENTS

RECIPIENT #________________ CARD ISSUE #__________________________
OTHER ELIGIBLE HOUSEHOLD MEMBERS:

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You may attach a separate sheet if necessary.
****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: ___________________________________________________________________
The local Area Agency on Aging is requesting the following information to complete State Reporting Requirements. This information is not used to determine eligibility for LIFT services. Providing this information is completely voluntary.

If you are over 65 years of age please check the appropriate boxes below:

- African-American
- Hispanic Origin
- American Indian or Native Alaskan
- Asian/Pacific Islander
- Non-Minority/Caucasian
- Race/Ethnicity Unknown
- Living in Poverty
- Minority Living in Poverty
- Live in Rural Area