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:

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-OO, 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*