

MATP REGISTRATION - Application Assessment



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 License 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.		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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 <input type="checkbox"/>	Manual Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing Disability <input type="checkbox"/>	Motorized Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Visual Disability <input type="checkbox"/>	Scooter <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cognitive Disability <input type="checkbox"/>	Oversized Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Behaviorial Health <input type="checkbox"/>	Walker <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gross Obesity <input type="checkbox"/>	Crutches <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other <input type="checkbox"/>	Braces <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Service Animal <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Other (Describe) <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligibility Date:	Recipient Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Notified:
Application: <input type="checkbox"/> Sent <input type="checkbox"/> In-person	Date Application Sent:	Date Application Returned:	Received By:
Assigned Transportation Mode: <input type="checkbox"/> Fixed Route <input type="checkbox"/> Mileage Reimbursement <input type="checkbox"/> DOT Shared Ride <input type="checkbox"/> Contracted Volunteer Driver <input type="checkbox"/> Paratransit			
MATP Funding Status: <input type="checkbox"/> Group I <input type="checkbox"/> 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. Please check all mobility aids that apply.

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Mobility disability (please see question to the right) | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Vision disability | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Hearing disability | <input type="checkbox"/> Motorized Scooter | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Cognitive disability | | |
| <input type="checkbox"/> Mental disability | | |
| <input type="checkbox"/> Other — Please specify: _____ | | |

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**