Elk • Cameron • McKean

APPLICATION FOR ATA-MATP SERVICES

AREA TRANSPORTATION AUTHORITY OF NORTH CENTRAL PENNSYLVANIA

1.866.282.4968

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

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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:			

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Verification of Disability or Special Needs Page 1 of 2

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City:	Municipality:	County:	State:	Zip:
Emergency Contact:	Relationship:	Phone #:	

Recipient Release

I understand the purpose of this evaluation is to help determine the most cost effective and appropriate mode of transportation for me. I understand the information about my disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby authorize my medical representative to release any and all information required by the Medical Assistance Transportation Program regarding my medical condition, for the purpose of determining an appropriate method of transporting me to medical services. 55 Pa. Code § 2070.25 ***requires*** providers of medical services to give access to and allow the use and disclosure of information on applicants and clients if the information is necessary to the administration of the Public Assistance Transportation Block Grant.

Signature of Applicant ____________ Date Signed ____________

If the MATP recipient or applicant is unable to sign this form (e.g. minor, disability, etc.) he/she may have someone sign and certify (below) on his/her behalf.

Signature of Designee ____________ Date Signed ____________ Relationship ____________

Physician Certification

The individual named above has the following disability(ies.) Check all that apply.

- ☐ OVR
- ☐ SSI/SSDI
- ☐ Bureau of Blindness & Visual Services
- ☐ MH/MR
- ☐ United Cerebral Palsy (UCP)
- ☐ Registered Physical/Occupational Therapist

The individual named above receives, or is eligible for, disability services from these programs. Check all that apply.

- ☐ OVR
- ☐ SSI/SSDI
- ☐ Bureau of Blindness & Visual Services
- ☐ Center for Independent Living
- ☐ MH/MR
- ☐ United Cerebral Palsy (UCP)
- ☐ Registered Physical/Occupational Therapist
- ☐ Physician
- ☐ Registered Nurse
- ☐ PA Attendant Care
- ☐ Other

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Verification of Disability or Special Needs Page 2 of 2

Limitations	These Limitations Apply				Status		
Indicate the tasks (below) related to using public transit that the individual listed above cannot do.	**Always**	**Usually**	**Occasionally**	**Rarely**	**Permanent**	**Temporary**	**If temporary, how long?**
Boarding vehicle without a wheelchair lift or ramp	☐	☐	☐	☐	☐	☐	
Recognizing a bus stop, identifying appropriate bus and route #	☐	☐	☐	☐	☐	☐	
Understanding/handling bus fare/money transactions	☐	☐	☐	☐	☐	☐	
Recognizing destinations if stops are announced	☐	☐	☐	☐	☐	☐	
Waiting for an hour	☐	☐	☐	☐	☐	☐	
Walking less than a 1/4 mile	☐	☐	☐	☐	☐	☐	
Communicating with people	☐	☐	☐	☐	☐	☐	
Understanding emergencies or handling emergencies well	☐	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	☐	

Does the individual listed above require a personal care attendant (for medical reasons)or escort for assistance while traveling ? ☐Yes ☐No

Explain:

Physician Signature

55 Pa. Code § 2070.25 requires providers of medical services to give access to and allow the use and disclosure of information on applicants and clients to: Federal authorities, the Commonwealth, the Department, the County Commissioners or County Executive, and prime contractors or their authorized agents, if the information is necessary to the administration of the Public Assistance Transportation Block Grant. I hereby authorize and request the disclosure to the Medical Assistance Transportation Program any information concerning the age, residence, citizenship, employment, education and training activities, and any additional information, including medical information and treatment plans, pertaining to eligibility for Medical Assistance Transportation and /or specific transportation requests under the MATP. It is understood that the information obtained will be used only for purposes directly related to the Medical Assistance Transportation Program. By signing, I affirm that to the best of my knowledge, the information in this evaluation form is true and correct. Furthermore, I certify that I have medical information on file to document the above statements and will produce such documentation at the request of the Medical Assistance Transportation Program Provider. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Signature ____________ Print or Type Name of Person Signing ____________ PA License Number ____________ Date ____________

Office Street Address ____________ City ____________ State ____ Zip ____ Office Phone ____________ Office FAX ____________

Authorization for the Release of Information

MATP PA 4

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SSN:	MA Recipient #:	Phone #:	
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Signature of Applicant | Date Signed

Applicant Name Printed

Signature of Designee (person signing on behalf of applicant) | Date Signed

Designee Name Printed

Signature of Witness | Date Signed | Title

Witness Name Printed