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 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 mean functions such as caring for oneself, 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 The LIFT @ 127 E 14TH St.* Erie *PA 16503 or fax 814-455-3530

Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

Social Security Number or MA ID: _____

II. AUTHORIZATION. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("Authorized Party") to use or disclose the following:

Any medical-related information needed to verify my receipt of medical services for the purpose described below

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

Name: Insert Name of MATP ADMINISTRATOR

Address: Insert Contact Information for MATP ADMINISTRATOR

Phone: (____)____ - _____ Fax: (____) ____ - _____

E-Mail: _____

IV. PURPOSE. The reason for this authorization is:

To verify attendance to the appointment for medical services for which you received transportation through the Medical Assistance Transportation Program.

V. TERMINATION. This authorization will terminate:

Upon sending a written revocation to the authorized party.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____

☐ - **Other:** _____

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____