MATP REGISTRATION - Application Assessment

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Clarion County Transportation
338 Amsler Avenue, Suite 1
Shippenville, PA 16254

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:			

Authorization for Release of Information - (MATP - PA4)

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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.

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 _____