INSTRUCTIONS FOR COMPLETING THE MEDICAL ASSISTANCE TRANSPORTATION APPLICATION

Welcome to the Medical Assistance Transportation Program. STEP Transportation is pleased to be able to provide eligible residents of Lycoming and Clinton County with no cost medical transportation services offered through the Medical Assistance Transportation Program.

Below you will find instructions for completing the enclosed Medical Assistance Transportation Program Application. Please complete this application and return it to the address listed ***within 30 days*** in order to continue to be eligible for the MATP. You may also fax the application to the fax number listed.

- ***Complete Each Section*** with all general information requested. Note: if you do not have a telephone, please include a telephone number and contact name where we can leave a message for you, as we will need to speak to you upon receipt of your application.

- ***Documents to Include*** with your Medical Assistance Transportation Application.

You will need to provide proof of your eligibility for the program. This is a general list of things that you are asked to provide a copy.

	Documents Needing Proof	Examples of Proof
1 2 3	Name(s) Age(s) Citizenship(s)	A document to verify each identity on the application, such as driver's license or photo ID, birth certificate, immigration papers, passport, or military papers.
4	Social Security Number(s)	Social Security card
5	Medical Assistance Eligibility	Pennsylvania ACCESS card or letter of application receipt

- ***Complete the Application*** by circling or checking any question or boxes that may apply.
- ***Sign and Date the application*.**
- ***Mail or fax the application, along with the requested documents to:***

STEP Transportation
2138 Lincoln Street
Williamsport, PA 17701
Fax: (570) 327-5455

Upon receipt of your application, STEP MATP staff will contact you to determine and discuss the most appropriate mode of transportation for you.

Thank you for applying for the Medical Assistance Transportation Program. We look forward to assisting you with your medical transportation needs.

CLIENT ID #

Application for MATP Services

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	10 Digit Recipient #:	Card Issue #:	Phone #:
Street Address:			Apt. #:
City:	Municipality:	County:	State/Zip Code:
Name of Emergency Contact:	Relationship:	Emergency Contact's Phone #:	

Do you live in a personal care home?	☐ Yes	☐ No	☐ I don't know
Does the personal care home receive an agreement to provide transportation services for you?	☐ Yes	☐ No	☐ I don't know
Do you live in a nursing home?	☐ Yes	☐ No	☐ I don't know

MATP Funding Status (Completed by Office Personnel) ☒ **Group I** ☐ **Group II**

List Other Eligible Household Members Below:

Name	DOB	Recipient #	Card Issue #	SSN	Mode	Frequency Wk - Mo	Status
					(Completed by Office Personnel)		

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 the 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 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:	Client 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 Program ☐ Contracted Volunteer Driver ☐ Paratransit			

CLIENT ID #

Authorization for Release of Information

(MATP – PA4)

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	10 Digit Recipient #:	Card Issue #:	Phone #:
Street Address:			Apt. #:
City:	Municipality:	County:	State/Zip Code:
Name of Emergency Contact:	Relationship:	Emergency Contact's Phone #:	

55 Pa. Code § 2070.25 requires providers medical service 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 or Designee Date Signed

_____

Applicant Name Printed

_____ _____ _____

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

_____

Designee Name Printed

_____ _____ _____

Signature of Witness Date Signed Title

_____

Witness Name Printed

Retain original on file until a new form is signed.

CLIENT ID #

Statement of Ownership of, Access to, and Ability to Utilize a Motor Vehicle

1. Do you have a valid driver's license?	☐ Yes ☐ No
2. Do you have a vehicle that is legally registered, insured, and drivable? If the vehicle is not available, explain why.	☐ Yes ☐ No
3. Do you have access to a vehicle belonging to a friend or other family member? If yes, please list full name and address:	☐ Yes ☐ No
4. Are you able to take yourself (and/or children) to medical appointments? If no, please select reason If other, please explain **(Supporting documentation/verification will be required)**	☐ Yes ☐ No ☐ Medical ☐ Employment ☐ Other
5. Do you have a relative or friend who is willing to take you to medical appointments? If so, locally? Out of town?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
6. If you do not have a vehicle, access to a vehicle, or a friend/relative willing to provide transportation – how are you now getting to other appointments, grocery shopping, or other personal needs? PARENT WHEN AVAILABLE	

The Medical Assistance Transportation Program reserves the right to verify all information with the Pennsylvania Department of Transportation (PennDOT) as well as the Department of Public Welfare. Failure to disclose complete and accurate information may result in suspension or termination of MATP services.

I, _____, attest that the answers to the above questions are true and honest to the best of my ability. I understand that if I fail to provide or fully disclose the information requested regarding ownership of, or access to a vehicle my MATP services may be suspended or terminated.

_____ _____

Signature of Applicant or Designee Date

Application for MATP Services
Assessment of Need

Complete for <u>each</u> MATP recipient listed on Application Page 1

CLIENT ID #

Last Name:	First Name:	Middle Initial:	Social Security #:
10 Digit Recipient #	Card Issue #:	**MATP Funding Status (Completed by Office Personnel)** ☒ Group I ☐ Group II	
Name of Emergency Contact:	Relationship:	Emergency Contact's Phone #:	
Do you live in a nursing home?	☐ Yes ☐ No ☐ I don't know		
Do you live in a personal care home?	☐ Yes ☐ No ☐ I don't know		
Does the personal care home receive an agreement to provide transportation services for you?	☐ Yes ☐ No ☐ I don't know		

Transportation Frequency (this information is needed to determine the frequency of ongoing transportation needed)

List known locations for medical services needed	Approx. Distance from home	# of weeks per month	Check the days of week transportation is needed to this location							Appt Time if known
			Mon	Tues	Wed	Thur	Fri	Sat	Sun	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	

Transportation Modes	Are there medical reasons why you cannot use this mode
Fixed routs (If available)	☐ Yes ☐ No
Paratransit Services (If available)	☐ Yes ☐ No
Taxis (If available)	☐ Yes ☐ No
Do you live ¼ mile or less from bus route services?	☐ Yes ☐ No

If there are medical reasons why you cannot use the above transportation modes, we need a "Verification of Disability and Special Needs" form completed by your medical provider.

Application for MATP Services
Assessment of Need

Complete for <u>each</u> MATP recipient listed on Application Page 1

CLIENT ID #

Limitations and Disabilities

Can you speak and understand English?	☐ Yes ☐ No	
If not, what language do you speak?		
Will you be traveling with a **Personal Attendant** or **Escort**?	☐ Yes ☐ No	**If Yes and the recipient is not a child, we need a "Verification of Disability and Special Needs" form completed by your medical provider.**
Do you have a disability that requires special accommodation?	☐ Yes ☐ No	**If Yes, we need a "Verification of Disability and Special Needs" form completed by your medical provider.**

Nature of Disability	**Check all that apply**	**Use of Mobility Aid**	**Check if you use this mobility aid**	**Is the use of this aid temporary?**	**Date temporary need will end**	**Comments and Descriptions**
Mobility Disability	☐	Manual Wheelchair	☐	☐ Yes ☐ No		
Hearing Disability	☐	Motorized Wheelchair	☐	☐ Yes ☐ No		
Visual Disability	☐	Scooter	☐	☐ Yes ☐ No		
Cognitive Disability	☐	Oversized Wheelchair	☐	☐ Yes ☐ No		
Behavioral Health Disability	☐	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 and 48" in length (measured 2 in. above the ground) and weigh no more than 600 lbs 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

Application for MATP Services
Verification of Disability or Special Needs

Complete for <u>each</u> MATP recipient listed on Application Page 1

CLIENT ID #

Applicant Section

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	10 Digit Recipient #:	Card Issue #:	Phone #:
Street Address:			Apt. #:
City:	Municipality:	County:	State/Zip Code:

Applicant Release Section

I understand that the purpose of this evaluation is to help in determine the most cost effective and appropriate mode of transportation for me. I understand that 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.

Applicant Signature Date

If applicant is unable to sign this form he/she may have someone sign and certify (below) on applicant's behalf (e.g., minor, disability)

Signature of Person Signing for Applicant	Date	Print Name	Relationship to Applicant

Certification Section

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

☐ Mobility ☐ Vision ☐ Hearing

☐ Cognitive ☐ Behavioral ☐ Other

Application for MATP Services
Verification of Disability or Special Needs

Complete for <u>each</u> MATP recipient listed on Application Page 1

CLIENT ID #

Limitation Section

Indicate the tasks (below) related to using public transit that the individual listed above cannot do.	These limitations apply				Status		
	Always	Usually	Occasionally	Rarely	Permanent	Temporary	If so, 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 (describe):	☐	☐	☐	☐	☐	☐	

Does the individual require a personal care attendant or escort for assistance while traveling ☐ Yes ☐ No

Certification Section

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	

Verification Section

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.

Print or Type Name of Person Signing	Signature	Pennsylvania License # (if applicable)	Date

Office Street Address, city, state & zip	Office Phone #	Office Fax #

Receipt of Program Documentation

(MATP)

CLIENT ID #

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	10 Digit Recipient #:	Card Issue #:	Phone #:
Street Address:		Apt. #:	
City:	Municipality:	County:	State/Zip Code:

I have been given all of the policies and procedures paperwork pertaining to this program and understand them to the best of my knowledge, including the scheduling procedures and times.

_____ _____

Signature of Applicant or Designee Date Signed