Application for Transportation Services

Instructions

The purpose of this application is to collect the required information to determine eligibility for services. The information provided in this application regarding your age, disability, and county of residence will be used to determine your eligibility for shared ride transportation services under the Rural Transportation Program for Persons with Disabilities (PwD), Americans with Disabilities Act (ADA), Medical Assistance Transportation Program (MATP), or Senior Shared Ride programs. Other information within the form will be used for data collection purposes. Appropriate referral service will be provided if applicable. This information will be kept confidential and used only by the professionals involved in evaluating your eligibility.

Important: Read all instructions carefully

- **ALL APPLICANTS** must complete parts 1, 2, 5, and 6

Eligibility Verification Documents required

- **MATP, age 0-64** , must provide Medical Assistance Verification

- **Lottery Program, age 65+** , must provide one proof of age from the following documents:
  - Driver's license or photo ID card
  - Birth certificate or church baptismal record
  - Naturalization or immigration paper, if age is shown
  - Military discharge paper, if age is shown
  - Passport
  - Statement of Age from the Social Security Administration

- **PwD/ADA, age 18-64** , must provide both :
  - Completed Certificate of Disability Form or Social Security Disability Award Letter
  - One proof of age from the list under Lottery Program above

Please complete this form and submit with a copy of required documents to: STEP Transportation, 2138 Lincoln Street, Williamsport PA 17701 **or** email to trcenter@stepcorp.org.

If you have any questions about this application or need this form in an alternate format, please contact STEP Transportation at **570.323.7575** or **800.222.2468**.

Section 1: General Applicant Information

All applicants must complete this section.
Applicants age 65+ must provide <u>one</u> proof of age from the following documents:
Driver's license or photo ID card, birth certificate or church baptismal record, naturalization or immigration paper (if age is shown), military discharge paper (if age is shown), passport, Statement of Age from the Social Security Administration.

Name First Name | Middle Name | Last Name | Suffix

Date of Birth mm-dd-yyyy **Today's Date** mm-dd-yyyy

Social Security # **Email**

Address Street Address

Street Address Line 2

City | State | Zip Code

County of Residence

Home Phone Number **Cell Phone Number**

Name of Emergency Contact **Relationship**

Do you live in a nursing home? ☐ YES ☐ NO

Are you being discharged from a nursing home within the next 2 weeks? ☐ YES ☐ NO

Do you live in a personal care home? ☐ YES ☐ NO

If "yes" does your care agreement include transportation? ☐ YES ☐ NO ☐ NOT SURE

Are you a US Armed Forces veteran? ☐ YES ☐ NO

Do you need an escort to assist with transportation? ☐ YES ☐ NO

Do you speak English? ☐ YES ☐ NO

If you do not speak English, what language do you speak?

Will you need an interpreter? ☐ YES ☐ NO

Note: STEP Transportation utilizes Language Service Associates to provide translation services.

Please check all mobility aids that you use:

☐ Manual wheelchair ☐ Motorized wheelchair ☐ Scooter ☐ Oversized wheelchair

☐ Walker ☐ Crutches ☐ Braces ☐ Service Animal ☐ Other

Is the use of your mobility aid(s) temporary?

☐ YES ☐ NO

If "yes," date usage of mobility device will end:

If you utilize a wheelchair, is your wheelchair greater than 30 inches in width or 48 inches in length, as measured 2 inches above the ground?

☐ YES ☐ NO ☐ N/A

Does your wheelchair weigh less than 600 pounds when occupied?

☐ YES ☐ NO ☐ I do not use a wheelchair

If you utilize a mobility device, can you transfer to a seat?

☐ YES ☐ NO ☐ I do not use a wheelchair

Section 2: Program Assessment

All applicants must complete this section.

Are you between the ages of 18-64 and have a disability as defined by the Americans with Disabilities Act (ADA)? ☐ YES ☐ NO

Under the ADA, you have a disability if you have a physical or mental impairment that substantially limits a major life activity. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

If you answered YES to this question, please complete Section 3.

Are you eligible for Medial Assistance? ☐ YES ☐ NO

If you answered YES to this question, please complete Section 4.

If you answered NO to both questions, please proceed to Section 5.

Section 3: Persons with Disabilities (PwD) / Americans with Disabilities Act (ADA) Application

Is your disability permanent (lasting 12 months or longer)? ☐ YES ☐ NO

If "no," what is the expected duration of this disability?

What is the nature of your disability? Check all that apply.

☐ Mobility disability ☐ Hearing disability ☐ Visual disability ☐ Cognitive disability
☐ Behavioral health ☐ Gross obesity ☐ Other

Please describe how this disability restricts you from riding the fixed route bus:

Do you know that River Valley Transit fixed route buses are fully ADA compliant with wheelchair securement areas and preferential seating for the disabled? ☐ YES ☐ NO

Can you ride the regular fixed route bus on certain occasions? ☐ YES ☐ NO ☐ SOMETIMES

If "yes" or "sometimes", please specify when you can ride the fixed route:

Have you ridden the River Valley Transit fixed route bus within the last 4 weeks? ☐ YES ☐ NO

Can you wait at a bus stop for up to 10 minutes at a time? ☐ YES ☐ NO ☐ SOMETIMES

If "yes" or "sometimes," please specify when you can stand at a bus stop.

Can you travel, unassisted: (check all that apply)

- ☐ 200 feet
- ☐ 3 blocks or about 1/4 mile
- ☐ 6 blocks or about 1/2 mile
- ☐ 9 blocks or about 3/4 mile

Please list the name and phone number of your primary care physician OR the physician that can verify the information you have provided in this application.

Physician's Name _____

Phone Number _____

You may already have written verification of a disability from a service organization by having an identification card, or a written assessment of your disability. If so, you will need to provide us with a copy of this information.

If you do not have written verification of a disability, please have a professional* who is familiar with your disability fill out the Certification of Disability Form. The form provides verification of your disability.

*A professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services to people with disabilities.

PwD/ADA, age 18-64, must provide both:

- *Completed Certificate of Disability Form or Social Security Disability Award Letter*
- *One proof of age from the following documents: driver's license or photo ID card, birth certificate or church baptismal record, naturalization or immigration paper (if age is shown), miliary discharge paper (if age is shown), passport, Statement of Age from the Social Security Administration.*

Section 4: MATP Application

MATP applicants must provide Medical Assistance verification.

Do you have a Medicaid card? ☐ YES ☐ NO

If "yes", please provide the following:

Recipient # _____

Card Issue # _____

Does anyone in your household use MATP presently? ☐ YES ☐ NO

Do you live near a bus stop (within a quarter mile)? ☐ YES ☐ NO

Do you have a valid driver's license? ☐ YES ☐ NO

Do you have a vehicle that is legally registered, insured, and driveable? ☐ YES ☐ NO

Do you have access to the vehicle of a friend or relative? ☐ YES ☐ NO

Is someone you know able to transport you to medical appointments? ☐ YES ☐ NO

Are there medical reasons that you cannot ride in a vehicle with other people? ☐ YES ☐ NO

Are there medical or cognitive reasons that you cannot ride on Fixed Route Transportation (bus)? ☐ YES ☐ NO

Section 5: Release of Information

55 Pa. Code § 2070.25 requires providers of 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 my representatives to release any and all information required by STEP Transportation for the purpose of determining an appropriate method for the purpose of transporting me to various services.

I hereby authorize and request the disclosure of medical information to the Medical Assistance Transportation Program. I also hereby authorize the release of 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 MATP. It is understood that the information obtained will be used only for purposes directly related to the Medical Assistance Transportation Program or the Shared-Ride Transportation Program.

STEP Transportation reserves the right to verify all information with the Pennsylvania Department of Transportation (PennDOT) as well as the Department of Human Services. Failure to disclose complete and accurate information may result in suspension or termination of MATP/Shared-Ride services.

Signature of Applicant or Designee

Name of Designee (person signing on behalf of applicant)

First Name | Middle Name | Last Name | Suffix

Designee Title

Date Signed

Section 6: Certification of the Application

I hereby certify that to the best of my knowledge, the information contained herein is true, correct and complete.
I understand and agree to the following:

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

2. I will report any changes in circumstances immediately to the STEP Transportation.

3. 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.

4. **MATP customers only:** I have a right to request a Department of Human Services fair hearing if Medical Assistance Transportation benefits are denied. This affirmation statement covers all attachments required for the determination of eligibility.

5. **MATP customers only:** 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.

6. 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, _____ ,attest that the answers to the above questions are true and honest to the best of my ability.
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 or Shared-Ride Provider. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania. 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

Name of Applicant

First Name	Middle Name	Last Name	Suffix

Name of Designee (person signing on behalf of applicant)

First Name	Middle Name	Last Name	Suffix

Title of Desginee

Date Signed