pennsylvania
DEPARTMENT OF HUMAN SERVICES

MATP REGISTRATION - Application Assessment

Fayette Area Coordinated Transportation
825 Airport Rd, Lemont Furnace PA 15456
(724) 628-7433

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.		
New Directions		4	☒	☒	☒	☒	☒	☐	☐	8:40 - 3:00 pm pm	Summer program
			☐	☐	☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐	☐	☐		

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		N/A
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:			

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Verification of Disability or Special Needs

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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

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 lisrted 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
STC/ND			

Office Street Address	City	State	Zip	Office Phone	Office FAX
125 Chaffee Street	Uniontown	PA	15401	724-434-5437	724-434-1014

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Receipt of Program Information

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Publication or Policy		Comments
Authorization to Release Information (MATP/PA-4)	☒ Received	
Welcome Brochure	☑ Received	
No-Show Policy	☒ Received	
Escort Policy	☐ Received	N/A
Paratransit Pick-up Rule	☒ Received	
Paratransit One-Hour Rule	☒ Received	
Quarter Mile Rule	☒ Received	
Mileage Reimbursement Policy	☒ Received	N/A
Urgent Care Policy	☐ Received	N/A
Closest Methadone Clinic Regulation	☐ Received	N/A
Transportation Access Standards	☒ Received	
Complaint Policy	☑ Received	
	☐ Received	

Rights and Responsibilities

RIGHT TO NONDISCRIMINATION

The Commonwealth of Pennsylvania prohibits discrimination on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, or sexual orientation.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to determine eligibility and type of transportation for which you qualify.

RIGHT TO A WRITTEN NOTICE

If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if the MATP fails to act on your application. You may file the appeal at the Couny MATP office. If you appeal, you may also request a Conty agency conference before the hearing. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct, and complete information. You must help in proving the information you give. Transportation may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the County MATP office to help you obtain it. If you are contacted by DHS or the Office of Inspector General, you must fully cooperate with those persons or investigators.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

On application, you must provide a Social Security Number (SSN) for each person for whom you are applying. Your SSN will be used for identity and along with your MA Identification number to verify your Medical Assistance eligibility, category, and program code.

RESPONSIBILITY TO USE THE MATP LAWFULLY

Once you are determined eligible for the MATP, you may only use transportation (or receive mileage reimbursement) for services that are elligible MA covered medical services and are allowed by the MATP.

RESPONSIBILITY TO REPORT CHANGES

When receiving MATP services, you are required to report changes in your circumstances to the County MATP office as well as your caseworker at the County Assistance Office (CAO) or to the Statewide Customer Service Center. Types of changes reported would include a new address, new phone number, or new working hours that could affect the availability of an automobile if you receive mileage reimbursement. You are also required to report and verify any changes in mobility or physical ability that would affect your assigned mode of transportation. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report address and phone changes to the CAO in person, by phone, fax, mail or through a COMPASS account. You may also report changes to the Statewide Customer Service

Recipient Verification

By signing this form, I agree and attest I have received and understand the policy information provided as well as my rights and responsibilities outlined above. I understand that there are additional policies and procedures contained in the Medical Assistance Transportation Program Standards and Guidelines which determine the operation and scope of the MATP and by which I must also abide.

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 _____

Authorization for Release of Information - (MATP - PA4)

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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 _____

Kerri Myers
Signature of Witness _____ Date Signed _____ Secretary
Title

Kerri Myers
Witness Name Printed