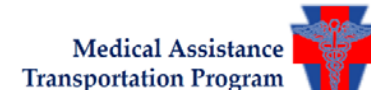


## Verification of Disability or Special Needs



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 #:	

Recipient Release
<p>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 <i>requires</i> 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.</p>

\_\_\_\_\_ 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.			
<input type="checkbox"/> OVR	<input type="checkbox"/> SSI/SSDI	<input type="checkbox"/> Bureau of Blindness & Visual Services	
<input type="checkbox"/> MH/MR	<input type="checkbox"/> United Cerebral Palsy (UCP)	<input type="checkbox"/> Registered Physical/Occupational Therapist	
The individual named above receives, or is eligible for, disability services from these programs. Check all that apply.			
<input type="checkbox"/> OVR	<input type="checkbox"/> SSI/SSDI	<input type="checkbox"/> Bureau of Blindness & Visual Services	<input type="checkbox"/> Center for Independent Living
<input type="checkbox"/> MH/MR	<input type="checkbox"/> United Cerebral Palsy (UCP)	<input type="checkbox"/> Registered Physical/Occupational Therapist	<input type="checkbox"/> Physician
<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> PA Attendant Care	<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognizing a bus stop, identifying appropriate bus and route #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Understanding/handling bus fare/money transactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Recognizing destinations if stops are announced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Waiting for an hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking less than a 1/4 mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communicating with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Understanding emergencies or handling emergencies well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does the individual listed above require a personal care attendant (for medical reasons) or escort for assistance while traveling ? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Explain:							

Physician Signature			
<p><b>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.</b></p> <p>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.</p>			
_____ Signature	_____ Print or Type Name of Person Signing	_____ PA License Number	_____ Date
_____ Office Street Address	_____ City	_____ State	_____ Zip
		_____ Office Phone	_____ Office FAX