



Pennsylvania
DEPARTMENT OF HUMAN SERVICES

MATP REGISTRATION - Application Assessment

Fayette Area Coordinated Transportation
825 Airport Rd, Lemont Furnace PA 15456
(724) 628-7433
(724) 628-7468 Fax

Medical Assistance
Transportation Program



Recipient Identification

Last Name:		First Name:		Initial:		Date of Birth:	
SSN:		MA Recipient #:		Phone #:		Apartment #:	
Street Address:		Municipality:		County:		State:	
City:		Relationship:		Phone #:		Zip:	
Emergency Contact:							

General Transportation Assessment

Do you speak English? Yes No If no, what language do you speak?

Do you have a valid Driver's License 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 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 Will you need to travel with an interpreter? Yes No

Do you need an escort to assist with your transportation? 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.		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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 <input type="checkbox"/>	Manual <input type="checkbox"/> Wheelchair <input type="checkbox"/> Motorized Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing Disability <input type="checkbox"/>	Walker <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Visual Disability <input type="checkbox"/>	Scooter <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cognitive Disability <input type="checkbox"/>	Oversized Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Behavioral Health <input type="checkbox"/>	Walker <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gross Obesity <input type="checkbox"/>	Crutches <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other <input type="checkbox"/>	Braces <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Service Animal <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Other (Describe) <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Eligibility Date:	Recipient Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Notified:
Application: <input type="checkbox"/> Sent <input type="checkbox"/> In-person	Date Application Sent:	Date Application Returned:	Received By:
Assigned Transportation Mode: <input type="checkbox"/> Fixed Route <input type="checkbox"/> Mileage Reimbursement <input type="checkbox"/> DOT Shared Ride <input type="checkbox"/> Contracted Volunteer Driver <input type="checkbox"/> Paratransit			
MATP Funding Status: <input type="checkbox"/> Group I <input type="checkbox"/> Group II			
Notes:			



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Authorization for Release of Information - (MATP - PA4)

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Emergency Contact:		Relationship:		Phone #:		Phone #:	

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 _____