Verification of Disability or Special Needs

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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 #:	

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 listed 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

Office Street Address	City	State	Zip	Office Phone	Office FAX