Medical Assistance Transportation Program
Application Verification of Disability or Special Needs

Applicant Section

Last Name: First Name: Initial: Date of Birth:

SSN: MA Recipient #: Telephone #:

Street Address: Apartment #:

City: Municipality: State: Zip Code:

Applicant Release Section

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 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 the appropriate method of transportation to medical services.

Applicant Signature: *Date:*

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 Person Signing for Applicant *Date* *Print Name* *Relationship to Applicant*

Continue on next page

Send or Fax completed form to:
Freedom Transit
50 E. Chestnut St
Washington, PA 15301
Fax: 724-223-9474

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Limitation Section

Indicate the task related to using public transit about the individual on the previous page.	These Limitations Apply				Status		
	Always	Usually	Occasionally	Rarely	Permanent	Temporary	If so, how long
Recognizing a bus stop, identify bus and route #							
Understanding/handling bus fare or monetary transactions							
Recognizing destinations when stops are announced							
Waiting for up to 1 hour							
Walking less than 1/4 mile							
Communicating with people							
Understanding emergencies or handling emergencies well							
Other (describe)							
Does the individual use a mobility device while traveling? List Device:_____						Y	N
Does the individual require a personal care attendant or escort for assistance while traveling?						Y	N

Certification Section

What is the nature of the applicant's disability? Please check the organization which has given written verification of a disability.

[ ] Mobility [ ] Hearing
[ ] Cognitive [ ] Other
[ ] Vision
[ ] Behavioral

[ ] OVR
[ ] MH/MR
[ ] Registered Nurse
[ ] SSI/SSDI

[ ] United Cerebral Palsy
[ ] PA Attendant Care Program
[ ] Bureau of Blindness and Visual Services
[ ] Registered Physical/Occupational Therapist

[ ] Center for Independent Living
[ ] Physician
[ ] Other

Verification Section

In signing, I acknowledge 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 undertsand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Print name of person signing | Signature | PA License # | Date

Office Street Address | City, State, Zip | Office Phone #