Medical Assistance Transportation

Section 1- General Information

Last Name:		First Name:	
Street Address:			
Street Address:			
City:	State:	Zip:	Boro/Township
Home Phone#		Mobile Phone#	
Social Security#:		Birthdate:	
Recipient#:			
Category:	PGM:	Group#	Access Plus/ Fee for Service

Other Eligible Household Members

Name	SS#	Birthdate	Recipient #	Cate	PGM	Group	AP/FS

Please note that children ages 0-8 years old must be in an appropriate child safety seat. USTA does not provide child safety seats. Transportation will be denied if you do not have the appropriate seat.

I hereby certify that 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 USTA. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or fir auditing purposes and that giving knowingly false statements is a criminal's offense. I understand that I have a right to request a Department of Public Welfare fair hearing. The affirmation statement covers all attachments required for the determination of eligibility.

Signature of client	Date	Signature of Interviewer	Date

The information obtained will assist the MATP provider in determining the appropriate mode(s) of transportation to meet your needs in accordance with MATP program guidelines and regulations. Consumers will be required to accept the most cost–effective mode of travel that meets their needs.

SECTION I – Consumers name

Last Name	First Name	Middle Initial

SECTION 2 - NURSING HOME/PERSONAL CARE HOME INFORMATION	Circle One
Do you live in a nursing home?	Y N
Do you live in a personal care home?	Y N
Does the personal care home receive an agreement to provide transportation services for you?	Y N

SECTION 3 – SPECIAL NEEDS

1. LANGUAGE

Can you speak and understand English? Y N If not, what language do you speak? ____________________

2. DISABILITY ACCOMMODATION SECTION

Please check any disability listed below that should be considered in determining the appropriate modes (s) of travel for you.

Nature of Disability	Check all that apply	Additional Notes:
Mobility Disability	☐	
Hearing Disability	☐	
Visual Disability	☐	
Cognitive Disability	☐	
Behavioral Health Disability	☐	
Gross Obesity	☐	
Other	☐	

3. USE OF MOBILITY AIDES	Check if you use this mobility aid	I only need this mobility aid temporarily	Date no longer needed (Complete only if this aid is needed temporarily)
Manual Wheelchair			
Motorized Wheelchair			
Scooter			
Oversized Wheelchair			
Walker			
Crutches			
Lift Mechanism to enter Vehicle			
Braces			
Service Animal			
Other (describe)			
None			

4.	Is your wheelchair/scooter greater than 30" in width and 48" in length (measured 2 inches above the ground) and weigh no more than 600 lbs when occupied?	Y	N
5.	Can you maneuver your wheelchair/scooter in a small confined area?	Y	N
6.	Can you transfer to a seat?	Y	N
7.	Do you need assistance to transfer to a seat?	Y	N

SECTION 4 – ESCORT INFORMATION

1. Will you be using an escort?	Yes No

Name of Emergency Contact	Phone #	Relationship

SECTION 5 – MILEAGE REIMBURSMENT INFORMATION

How many vehicles are there in the household? ____________

Do you have family or friends who can transport you to your appointments? Yes No

If you do not have available transportation, how are you grocery shopping or meeting other personal needs?

____

Is the reason consumer is unable to drive medical? Yes NO

Is **If so written documentation is required from a medical provider stating consumer is unable to drive and the length of time the restriction exists.**

Do you or the person driving have a valid driver's license? Yes No Seen yes or no

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Signature of Consumer	Date
Signature of Interviewer	Date