Assessment of Needs

SECTION 1 – GENERAL

Last Name	First Name	Middle Initial	Date of Birth

Street Address:			Apartment #
City	Municipality	State PA Zip Code	Telephone #
Mailing Address:			Cell #

SECTION 11 – MEDICAL ASSISTANCE ELIGIBILITY INFORMATION

Recipient # (10 Digit # on Access Card)	Card Issue # (2 Digit # following the 10 digit # on Access Card)	Group #	Social Security #

NURSING HOME/PERSONAL CARE HOME INFORMATION	Circle One
Do you live in a nursing home?	Y N I don't know
Do you live in a personal care home?	Y N I don't know
Does the personal care home receive an agreement to provide transportation services for you?	Y N I don't know

Other Eligible Household Members (List)

For Children under age 8, this section is required under the PA Child Passenger Protection Laws

Name	Birth Date	Recipient #	Card #	Group #	SSN	Height	Weight

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 the Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Public Welfare Fair Hearing if benefits are denied. This affirmation statement covers all attachments required for the determination of eligibility.

Signature of Client	Date

FOR OFFICE USE ONLY – DO NOT COMPLETE BELOW THIS LINE

Applicant Determined Eligible (circle one) Y N	Reason for Ineligibility:

Date Initial Eligibility Determined:	
County Code Assignment:	
Date Client Notified:	

Signature of Interviewer	Date

Complete for each recipient listed on Page 1

Recipient Name:

Recipient # (10 Digit # on Access Card)	Card Issue # (2 digit # following the 10 digit # on Access Card)	Group #	SSN

Do you have a vehicle that you are able to drive?	Yes	No
Can you drive yourself to your appointments?	Yes	No
Do you have family or friends who can transport you to your appointments?	Yes	No

Frequency of Transportation Needed (this information is needed to determine the frequency of ongoing transportation needed)

List known locations for medical services needed	Approximate distance from home	# of weeks per month	Circle the days of week transportation is needed to this location							Appointment Time Known
			M	TU	W	TH	F	SA	SU	

Transportation Modes	Are there medical reasons why you cannot use this mode?*	
Fixed Routes (if available)	Y	N
Paratransit Services (if available)	Y	N
Taxis (if available)	Y	N

***If there are medical reasons why you cannot use above modes, we need a "*Verification of Disability and Special Needs*" form completed by your Medical Provider.**

Do you live ¼ mile or less from bus route services?	Y	N

Instructions to driver on where your home is (if you need paratransit services):

Name of Emergency Contacts	Phone #	Relationship

Complete for each recipient listed on Page 1

Recipient Name:

1. LANGUAGE

Can you speak and understand English? **Y** **N**

If not, what language do you speak? _____

2. ESCORT/PERSONAL CARE ATTENDANTS

Will you be traveling with a Personal Attendant or Escort? **Y** **N**

If the recipient is not a child, we need a medical statement verifying that you need to be escorted and a reason why this can be done through a letter from our doctor or by completing a form known as a "*Verification of Disability or Special Need".*

3. DISABILITY ACCOMODATION SECTION

Do you have a disability that requires special accommodation? **Y*** **N**

***If yes, attach a completed *"Verification of Disability or Special Needs"* form or a letter by your medical provider describing the accommodation you need.**

Nature of Disability	Check All that Apply
Mobility Disability	☐
Hearing Disability	☐
Visual Disability	☐
Cognitive Disability	☐
Behavioral Health Disability	☐
Gross Obesity	☐
Other	☐

4. Use of Mobility	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			
Braces			
Service Animal			
Other (describe)			
None			

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

Special Needs

Complete for each recipient listed on Page 1

Recipient Name:

Recipient Number:

1. Do you require the assistance of a Personal Care Attendant while traveling?	**Y N**
Name of Personal Care Attendant:	
2. Will you be using an escort? (This is not a Personal Care Attendant)	**Y N**
Reason for Escort (Attach documentation of need):	

3. DISABILITY ACCOMMODATION SECTION

Do you have an ADA disability that requires special accommodation? (Attach documentation of need)	**Y N**	
Nature of Disability (Check all that apply)	**Yes/No**	**Accommodation Requested**
Ambulatory		
Motor Dysfunction		
Visual Disability		
Cognitive Disability		
Uncontrolled Fatigue		
Mental Disability		
Obesity		

4. Use of Mobility Aids	**Check for Use of mobility aids used**	**This wheelchair or scooter meets ADA "common wheelchair" definition. Yes or No**	**Is it difficult to maneuver your wheelchair/scooter In a small confined area?**	**Can you transfer to a Seat?**	**Do you need assistance to transfer to a seat?**	**Mobility device is Needed Permanently**	**Date no longer needed**
Manual							
Motorized Wheelchair							
Scooter							
Oversized Wheelchair							
Walker							
Crutches							
Braces							
Service Animal							

Reason for Escort (Attach documentation of need)

Application Section

Medical Assistance Transportation Program Application

Verification of Disability or Special Needs

APPLICANT SECTION

Last Name	**First Name**	**Middle Initial**

Street Address	**Apartment #**	**Telephone #** **Cell #**

City	**Municipality**	**State**	**Zip Code**

Mailing Address

APPLICANT RELEASE SECTION

I understand that the purpose of this evaluation is to help in determining 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 an appropriate method of transporting me to medical services.

Applicant Signature **Date**

If applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf (e.g. minor, disability)

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

CERTIFICATION SECTION

The individual name(s) above has the following disability(ies)

( ) Mobility	**( ) Vision**	**( ) Hearing**
( ) Cognitive	**( ) Behavioral**	**( ) Other**

Medical Assistance Transportation Program Application

Verification of Disability or Special Needs
LIMITATION SECTION

	These limitations apply				Status		
INDICATE THE TASKS RELATED TO USING PUBLIC TRANSIT THAT THE INDIVIDUAL LISTED ABOVE CANNOT DO	**ALWAYS**	**USUALLY**	**OCCASIONALLY**	**RARELY**	**PERMANENT**	**TEMPORARY**	**IF SO, 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							
Waiting for an hour							
Walking less than ¼ mile							
Communicating with people							
Understanding emergencies or handling emergencies well							
Other (describe)							
Does the individual require a Personal Care Attendant or Escort for assistance while traveling?						**Y**	**N**

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 understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Print or Type Name of Person Signing	**Signature**	**Pennsylvania License # (if applicable)**	**Date**

Office Street Address	**City**	**State**	**Zip Code**	**Office Phone #**	**Office Fax #**

CERTIFICATION SECTION

The individual name(s) above has the following disability(ies):

( ) OVR	**( ) SSI/SSDI**	**( ) Bureau of Blindness & Visual Services**	**( ) Centers for Ind. Lvg.**
( ) MH/MR	**( ) United Cerebral**	**( ) Registered Physical/Occupational Therapist**	**( ) Physician**
( ) Registered Nurse	**( ) PA Attendant Care**	**( ) Other**	

11/1/2010