CENTER FOR COMMUNITY BUILDING, INC.
3525 N. 6TH ST HARRISBURG, PA 17110
717-232-7009 - MATP OFFICE 717-232-9884 - FAX NUMBER

Application Section

Medical Assistance Transportation Program Application

Verification of Disability or Special Needs

APPLICANT SECTION

Last Name	First Name	Middle Initial

Street Address 1	Apartment #	Telephone #

City	Municipality	State	Zip Code

APPLICANT RELEASE SECTION

I understand that the purpose of this evaluation is to help in 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 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 names above has the following disability(ies)

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

Continue on back of page

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LIMITAITON SECTION

Indicate the tasks related to using public transit that the individual listed above cannot do.	These limitations apply				Status		
	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							
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 (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	Office Phone #	Office Fax #

CERTIFICATION SECTION

The individual names above has the following disability(ies)

[ ]	OVR	[ ]	SSI/SSDI	[ ]	Bureau of Blindness and Visual Services	[ ]	Ctr for Ind. Lvg
[ ]	MH/MR	[ ]	United Cerebral	[ ]	Registered Physical/Occupational Therapist	[ ]	Physician
[ ]	Registered Nurse	[ ]	PA Attendant Care	[ ]	Other		

***THE MEDICAL ASSISTANCE TRANSPORTATION PROGRAM PROVIDER IS REQUESTING MEDICAL INFORMATION, WITHOUT THE MEDICAL INFORMATION THIS FORM IS INCOMPLETE. ***