COMMUNITY TRANSIT
FRIENDLY • RELIABLE • DOOR-TO-DOOR

To Medical Assistance Transportation Program Applicants:

The enclosed form is an application to determine your eligibility for the Medical Assistance Transportation Program (MATP).

If your physician requests ParaTransit service for you:

- Complete the Certification of Disability
- They must provide a brief explanation of the functional disability, which prevents you from using public transportation.
- MATP provides the **least costly, most appropriate** mode of service.

You cannot use MATP:

- If you need emergency ambulance transportation
- For non-medical trips such as for grocery shopping or for social activities
- To obtain medical care that is not covered by Medical Assistance.

The verification process can take up to ***10 business days***. Once we determine your eligibility, you will receive written verification from Community Transit, notifying you which transportation mode you are approved for. To avoid delays, please make certain your form is ***complete and legible***.

Any applications submitted without the required information will be returned to the applicant. **Please note: we cannot approve your application without your Physician's signature**. Applications returned without the Physician's signature will be registered for reimbursement. We will call to verify.

It is the applicant's responsibility to get their forms completed and to send them into our office.

Submit your application to:

Community Transit of Delaware County
MATP
206 Eddystone Avenue
Suite 200
Eddystone, PA 19022
Fax: 610-490-3982

If you have any questions, please call us at 610-490-3975.
Thank you for your cooperation!

Revised 7/18/2017

Medical Assistance Transportation Program Application

SECTION I- Basic Information

Last:	First:	Middle Initial:	
Birth Date: / / Month Day Year	Social Security#	Recipient ID# (from ACCESS Card)	
Address:			
House Number and Street	Apt.#	City	Zip Code
Telephone#:	Cell Phone#:	Nearest Cross Street:	
Emergency Contact#:	Emergency Contact Name:	Relationship:	Email Address:

SECTION II- Transportation Information

	Check: YES or NO	
Do you have a vehicle that you are able to drive?	Yes	No
Do you use mass transit (SEPTA)?	Yes	No
Do you have family/friends who can take you to your appointments?	Yes	No
Are you registered with SEPTA Paratransit (CCT Connect)?	Yes	No
Do you live less than ¼ mile from mass transit (SEPTA) stop?	Yes	No
Do you have a SEPTA Reduced Fare Card?	Yes	No
Do you have a physical or mental disability that prevents you from using mass transit (SEPTA)? If yes, please have the ***Assessment of Needs Form*** completed by healthcare professional.	Yes	No

Section III- Authorization for Release of Information

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 Medical Assistance Transportation Block Grant. I hereby authorize and request the disclosure to the Medical Assistance Transportation Program any information concerning eligibility, specific transportation requests, verification of an appointment, including dates and times, verification of cancelled or missed appointments, and verification that a medical service was received. This release also includes only medical information that is relevant to the mode of transportation required and to any limitations a medical condition or diagnosis would place on provision of transportation. It is understood that the information obtained will be used for purposes directly related to the Medical Assistance Transportation Program.

✘ ____

Applicant's 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**

How did you hear about our services? ____

Federal regulations require us to ask for your ethnicity. This information is for statistical purposes only and will be held in the strictest of confidence by Community Transit. The completion of this section is optional and it will not have any bearing on your eligibility, determination of mode, or any service you receive.

Please check the box below that best describes your ethnic/racial identity:

- ☐ American Native
- ☐ Asian/Pacific Islander
- ☐ Black, Not Hispanic
- ☐ Hispanic
- ☐ White, Not Hispanic
- ☐ Other

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Assessment of Needs

Name: ______________________ **Social Security#:** ______________________

SECTION I—Medical Assistance Eligibility Information

Recipient ID # (10-Digit on Access Card)		Card Issue # (Last 2 digits on Access Card)	Date of Birth	
Is this address a nursing home?	No □	Yes □		
Do you live in a personal care home?	No □	Yes □		
Are you currently receiving transportation services at this address?	No □	Yes □	If yes, please state the service provider.	
Do you have family/friends that can transport you to your medical appointments?		No □	Yes □	Uncertain □
Do you live ¼ mile from a SEPTA route?		No □	Yes □	Uncertain □
Are your appointments within a ¼ mile of a SEPTA route?		No □	Yes □	Uncertain □
How do you get to your non-medical appointments such as shopping?				

SECTION II- Certification of Disability

To be completed by applicant's healthcare provider. Additional information may be attached to form.

1. Is the recipient able to ambulate within ¼ of a mile?	Yes ☐ (If yes, please skip to Question #2)	No* ☐
*Reason(s) paratransit is requested over reimbursement:		
*Please state the functional disability, which prevents the recipient from using mass transit (SEPTA) or mileage reimbursement:		
2. Does the recipient require a personal attendant or an escort?	Yes ☐	No ☐
3. Does the recipient have a disability that requires a special accommodation?	Yes ☐ (please explain below)	No ☐
If yes, please state the special accommodation(s)		

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Name: ____ Social Security:______________________________

SECTION II- Continued

4. Nature of Disability	**Disability**	**Check all that apply**	**Accommodation requested:**
	Ambulatory		
	Motor Dysfunction		
	Visual Disability		
	Cognitive Disability		
	Uncontrolled Fatigue		
	Mental Disability		
	Other:		

5. Use of Mobility Aids			
Mobility Aid	**Check all that apply**	**Temporary**	**Permanent**
	Cane	Need until:	
	Walker	Need until:	
	Braces	Need until:	
	Scooter	Need until:	
	Service Animal	Need until:	
	Other (please specify)	Need until:	
	Manual Wheelchair	Need until:	
	Motorized Wheelchair	Need until:	
	Oversized Wheelchair	Need until:	

Wheelchair Only:

***Please note**: Our wheelchair ramps have a loading capacity of 600 lbs, including the wheelchair, and are 28 ½ inches wide by 48 inches long with a door height of 5 feet.*

Is the recipient able to maneuver their wheelchair in a confined area?		
Are they able to transfer to a seat?		
Does the home have a ramp?		
No ramp? How many steps from the front door to the driveway or street?		

Name:____ Social Security:________________________________

Medical Assistance Transportation Program Application Verification of Disability or Special Needs
To be completed by a **Healthcare Professional**

The recipient is able to perform the following task:	Always	Usually	Occasionally	Rarely
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 ¼ mile				
Communicating with others				
Understanding emergencies or handling emergencies well				
Other (explain)				

Verification

I acknowledge, in signing, 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 with adherence to HIPAA. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Name:	Signature of Medical Evaluator:	Date:	License#
Street Address:	City:	State:	Zip Code:
Telephone:	Fax Number:		

Community Transit of Delaware County is Curb-to-Curb.
If Door-to-Door assistance is required, please complete the Door-to-Door Assistance Request Form.

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Request for Door to Door Service

As stated in the attached Passenger Assistance Policy, Community Transit offers curb-to-curb service, which is defined as assistance to enter and exit the vehicle only.

Door-to-door assistance is defined as assistance to and from the vehicle and to and from the entrance of the building. This assistance includes allowing the passenger to take the driver's arm, pushing a wheelchair, carrying grocery bags or packages (20 lb limit per bag, three bags maximum) and opening the entrance door. Assistance does not include the physical lifting of the passenger or lifting the wheelchair in any way. Drivers are prohibited from entering a person's home or a facility.

PHYSCIANS, PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ Door-to-door Service is needed
- ☐ This patient does not require Door-to-door Service

If Door-to-door Service is requested, please check all that apply:

- ☐ Wheelchair/Scooter
- ☐ Walker
- ☐ Cane/Crutch
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Cognitive Disability
- ☐ Other____

Name of Consumer: ____

Address: ____

____

____

Phone Number: ____

206 Eddystone Avenue
Eddystone, PA 19022
610-490-3960 – Scheduling
610-490-3975- MATP
FAX: 610-490-3982

Passenger Assistance Policy

Community Transit of Delaware County, Inc. is committed to providing safe, reliable and courteous transportation for all passengers.

1. Community Transit offers curb to curb service. Curb to curb service is defined as assistance to enter and exit the vehicle **only**.

2. Door to door assistance is defined as assistance to and from the vehicle and to and from the entrance of the building. This assistance includes allowing the passenger to take the driver's arm, pushing a wheelchair, carrying grocery bags or packages (20 lb limit per bag, three bag maximum) and opening the entrance door. Assistance does not include the physical lifting of the passenger or lifting the wheelchair in any way. Drivers are prohibited from entering a person's home or a facility.

3. If a passenger requires door to door assistance, they must first complete Community Transit's Special Needs Form. Door to door service will be provided if the physical or mental condition of the passenger is such that he/she cannot reach the entrance to their home or destination independently. However, Community Transit reserves the right to require that the passenger use a mobility aid (wheelchair, walker, etc.) to insure safe boarding and transport. Community Transit may deny assistance if the driver is unable to provide assistance safely.

4. All persons who are transported in a wheelchair must also have and use a wheelchair lap belt. Lap belts must be secured prior to loading the wheelchair on the lift. Community Transit will provide temporary lap belts for use on the vehicle while a passenger is obtaining his/her own lap belt. Lap belts are available for purchase at cost by contacting the Community Transit Administrative Office at 610-490-3977.

5. Passengers in wheelchairs will be provided with assistance to enter and exit a lift equipped vehicle.

6. All residences must have easy access for persons who have mobility impairments. Access must be paved, cleared of snow and ice and have either a level or ramped surface. Passengers are responsible to rectify accessibility problems at their residence. Community Transit will provide resource information to passengers upon their request.

7. Individuals who require additional assistance beyond the assistance Community Transit offers are required to provide and travel with an escort. An escort is defined as an able bodied person with the ability to provide the necessary assistance. Community Transit will make the final determination concerning the need for an escort and Community Transit's procedures for approval of an escort must be followed.
If an escort is required, the passenger must always travel with an escort.

8. Community Transit reserves the right to deny transportation if Community Transit determines that transportation cannot be provided in a safe manner. Further, Community Transit does not accept any liability for any passenger who fails to comply with this policy

THIS IS YOUR COPY OF THE PASSENGER POLICY

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