

**Franklin County Transportation**  
**Medical Assistance Transportation Program**

Name: \_\_\_\_\_ MA # \_\_\_\_\_  
(Last) (First)

Birth Date: \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

**SECTION 1: Determination of mode of transportation**

1. Do you have access to a vehicle?  **Yes**  **No**
2. Can you drive yourself to your appointment?  **Yes**  **No**  
If not, please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Do you have family/friends that can transport you to appointments?  **Yes**  **No**
4. Do you have any medical appointments outside of Franklin County?  **Yes**  **No**
5. Would you like to register for the mileage reimbursement program?  **Yes**  **No**  
If yes, please complete mileage reimbursement paperwork
6. Do you live ¼ mile or less from your appointment?  **Yes**  **No**
7. Are you able to walk ¼ of a mile?  **Yes**  **No**
8. Do you live in a Personal Care Home/Nursing Home?  **Yes**  **No**
9. Does the home have an agreement to provide transportation for you?  **Yes**  **No**
10. Can you speak and understand English?  **Yes**  **No**
11. What language do you speak? \_\_\_\_\_
12. Do you have other members in your family who are registered with Franklin County Transportation? If yes, please list names  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 2: Mobility Aides and Escorts**

1. Do you use any of the following mobility devices? **Braces**\_\_ **Cane**\_\_ **Walker**\_\_ **Crutches**\_\_  
**Service Animal**\_\_ **Wheelchair**\_\_ **Electric**\_\_ **Oversized-chair**\_\_  **Scooter**\_\_ **Reclining** \_\_
2. Have you read and understand the “Wheelchair Policy” ? \_\_ **Yes** \_\_ **No**
3. Is your ramp made according to the ADA specifications? (1 ft per inch) \_\_ **Yes** \_\_ **No**
4. Please check any of the following three statements about your wheelchair  
\_\_ **Greater than 32 inches wide** (wheel to wheel) \_\_ **Greater than 48 inches in length**  
\_\_ **Weighs more than 600 lbs when occupied by you**
5. Is need for a mobility-aid temporary? **Yes**\_\_\_\_ **How long** \_\_\_\_\_
6. Can you maneuver your mobility aid in small confined areas? \_\_ **Yes** \_\_ **No**
7. Can you transfer from your wheelchair without assistance? \_\_ **Yes** \_\_ **No**
8. Can you get yourself to your destination once you go through the street door? \_\_\_\_\_  
**If you answered no to questions 5-8, you may need an escort.** Please refer to “Escort” in the User Guide. If escort is needed, they will need to register in order to ride with you.
9. Do you need an escort? \_\_ **Yes** \_\_ **No** (If yes, explain why you need an escort)  
\_\_\_\_\_

**Your signature to this registration form will also acknowledge that you have received a copy of the Franklin County Transportation Reference and User Guide. Your signing also represents that you understand and agree that it is your responsibility to read the user guide and to familiarize yourself and abide by the rules, policies and standards set forth by the public transportation provider, Franklin County Transportation. You further understand this agreement supersedes all prior agreements, understandings, and representation concerning Franklin County Transportation.**

\_\_\_\_\_  
**Rider’s signature**

\_\_\_\_\_  
**DATE**

**NOTE: The POA or responsible party are only to sign if the rider is unable and supply a brief explanation as to why the rider is unable to sign.**

\_\_\_\_\_  
**Franklin County Transportation will speak only to the names that appear on this form when receiving calls that ask to discuss or release information regarding the rider. Please place any name/names below that you wish to allow to speak on your behalf.**

\_\_\_\_\_  
NAME

\_\_\_\_\_  
Relationship to you

\_\_\_\_\_  
Rvvd 1/2012

Complete Section 1, Section II (access card information, social security number), Section V (sign and date)

## MEDICAL ASSISTANCE TRANSPORTATION PROGRAM ELIGIBILITY FORM

<b>SECTION I - HOUSEHOLD IDENTIFYING INFORMATION</b>									
NAME (Last, First, MI)				DATE OF BIRTH		TELEPHONE NUMBER			
ADDRESS (Street, City, Town, State, Zip Code)						COUNTY OF RESIDENCE			
<b>SECTION II - MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION</b>									
<b>MATP FUNDING STATUS</b> <input type="checkbox"/> GROUP I <input type="checkbox"/> GROUP II (D-00, D-05, B-00, PD-00, PD-21, PD-22, TD-00, TD-11, TB-00)									
<b>ACCESS CARD INFORMATION</b>		RECIP NUMBER			SOCIAL SECURITY NUMBER		CARD ISSUE NO.		
<b>EVS ELIGIBILITY INFORMATION</b>	DATE OF SERVICE								
	HEALTH CARE BENEFIT CODE								
	PROGRAM STATUS CODE								
	CATEGORY OF ASSISTANCE								
	PLAN NAME								
	HOTLINE NUMBER								
	LOCK IN INFO								
<b>OTHER ELIGIBLE HOUSEHOLD MEMBERS</b>									
NAME		RECIPIENT NUMBER	SSN	STATUS	DOB	GRP	MODE	FREQ/Wk-Mo	SPEC. NEED
<b>MODE KEY</b> <input type="checkbox"/> P = Public Transit <input type="checkbox"/> S = Shared Ride <input type="checkbox"/> A = Private Auto <input type="checkbox"/> V = Volunteer <input type="checkbox"/> O = Other (See Svc. Notes)									
<b>SECTION III - DETERMINATION OF NEED FOR SERVICES</b>									
<b>OTHER FUNDING SOURCES</b>		<input type="checkbox"/> PENNDOT 203	<input type="checkbox"/> DEPARTMENT OF AGING	<input type="checkbox"/> OTHER (Explain) _____					
<b>SPECIAL NEEDS</b>									
<b>MODE</b>									
<b>OTHER INFORMATION/ SERVICE NOTES</b>									
<b>SECTION IV - ELIGIBILITY DETERMINATION DECISION</b>									
<b>ELIGIBILITY STATUS</b>		<input type="checkbox"/> ELIGIBLE	<input type="checkbox"/> INELIGIBLE	<b>DATE CLIENT NOTIFIED</b>			<b>DATE ELIGIBILITY DETERMINED</b>		
<b>INELIGIBLE (Explain)</b>   									
<b>SECTION V - AFFIRMATION OF INFORMATION</b>									
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 this 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. This affirmation statement covers all attachments required for the determination of eligibility.									
<b>SIGNATURE OF CLIENT OR DESIGNEE</b>				<b>DATE SIGNED*</b>		<b>SIGNATURE OF INTERVIEWER</b>		<b>DATE SIGNED*</b>	