Application for Medical Assistance Transportation Program (MATP)
WARREN COUNTY TRANSIT AUTHORITY

Section 1 - General

Last Name:	First Name:	Middle Initial:	Date of Birth:
SSN:	Phone #:	Do you live a ¼ mile or less from bus route services? ☐ YES ☐ NO	
Street Address:		Apt. #:	
City:	Municipality:	County:	State/Zip Code:
Name of Emergency Contact:	Relationship:	Emergency Contact's Phone #:	

Section 2 – Medical Assistance Eligibility Information

Recipient # (10 Digit #)	Card Issue # (2 Digit #)	**MATP Funding Status (Completed by Office Personnel)**
		☐ Group I ☐ Group II

Other Eligible Household Members (List Below):

Name	DOB	Recipient #	Card Issue #	SSN	Mode	Frequency Wk - Mo	Status
					(Completed by Office Personnel)		

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.

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Signature of Client or Designee Date

FOR OFFICE USE ONLY		
Applicant Determined Eligible: ☐ **YES** ☐ **NO** (If not please state reason for ineligibility below)	Date of Initial Eligibility:	Date Client Notified:
Reason for Ineligibility:	Signature of Interviewer:	Date Signed:

Section 2 - Disability Accommodation Section:

Do you have a disability that requires special accommodation? ☐ YES ☐ NO
(If yes, attach a completed Verification of Disability or Special Needs or a Letter by your medical provider describing the Accommodation you need)

Nature of Disability	Check all that apply	Use of Mobility Aid	Check if you use this mobility aid	List any special needs associated with the use of this mobility aid.
Mobility Disability	☐	Manual Wheelchair	☐	
Hearing Disability	☐	Motorized Wheelchair	☐	
Visual Disability	☐	Scooter	☐	
Cognitive Disability	☐	Oversized Wheelchair	☐	
Behavioral Health Disability	☐	Walker	☐	
Gross Obesity	☐	Crutches	☐	
Other	☐	Braces	☐	
		Service Animal	☐	
		Other (Describe)	☐	

Is your wheelchair greater than 30" in width and 48" in length (measured 2 in. above the ground) and weigh no more than 600 lbs when occupied? ☐ YES ☐ NO ☐ Not Applicable

Can you transfer to a seat? ☐ YES ☐ NO

Do you need assistance to transfer to a seat? ☐ YES ☐ NO

ESCORT/PERSONAL CARE ATTENDANTS:

Will you be traveling with an Escort or Personal Care Attendant? ☐ YES ☐ NO

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 your doctor or by completing a form know as a "Verification of Disability or Special Need".

Section 3 - Determination of Need Checklist:

1. How did you hear about MATP?		
2. How many adults in the household?		
3. Do you have a valid driver's license? (If no skip to #7)	☐ YES	☐ NO
4. Do you have a vehicle that is legally registered, insured, and drivable? If the vehicle is not available, explain why. (If yes skip to #6 – If no skip to #5)	☐ YES	☐ NO
5. Do you have access to a vehicle belonging to a friend or other family member? (If yes, skip to #11, automatically mileage – If no skip to #7)	☐ YES	☐ NO
6. Are you able to take yourself (and/or children) to medical appointments? (If yes, skip to #11, automatically mileage)	☐ YES	☐ NO
7. Do you have a relative or friend who is willing to take you to medical appointments? If so, locally? Out of town? (If yes, automatically mileage – If no go on to #8)	☐ YES ☐ YES ☐ YES	☐ NO ☐ NO ☐ NO
8. If the person(s) applying do not have a vehicle, access to a vehicle, or a friend/relative willing to provide transportation – how are you/they getting to other appointments or shopping now?		
9. If you/they do not have a vehicle, etc. – is the public transit service available?	☐ YES	☐ NO
10. If on a public transit route, is it adequate to meet the need?	☐ YES	☐ NO
11. Is the person or, in case of a family, more than one adult working?	☐ YES	☐ NO
12. If yes, what hours does the person(s) work?		