



Medical Assistance Transportation Program Application

Section I—General Information

Name			
Last	First	Middle Initial	
Birth Date / / (Month) (Day) (Year)	Social Security # --- --- (On Access Card)	Recipient ID#	
Address			
House Number and Street	Apt. #	City	Zip Code
Telephone # () --	Cell Phone # () --	Nearest Cross Street	
Emergency Contact # () --	Emergency Contact Name	Relationship	e-mail address

Section II—Transportation Information

Do you have a vehicle that you are able to drive?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you use mass transit (SEPTA)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have family/friends who can take you to your appointments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you registered with SEPTA Paratransit (CCT Connect)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you live less than ¼ mile from a mass transit (SEPTA) stop?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a SEPTA Reduced Fare Card?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have a disability that requires special accommodation? If yes, please check all that apply: <input type="checkbox"/> Behavioral Health Disability <input type="checkbox"/> Cognitive Disability <input type="checkbox"/> Hearing Disability <input type="checkbox"/> Mobility Disability <input type="checkbox"/> Visual Disability <input type="checkbox"/> Other, please specify _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you use mobility aids? If yes, please select all that apply. <input type="checkbox"/> Braces <input type="checkbox"/> Crutches <input type="checkbox"/> Motorized wheelchair <input type="checkbox"/> Oversized wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Service animal <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Can you transfer to a seat?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you need an interpreter?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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 a healthcare professional.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Section III—Applicant Release

I understand that the purpose of this evaluation is to aid 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. Any information about my disability will be shared only with professionals who are 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 determining an appropriate method of transporting me to medical services.

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

Print Name

Relationship to Applicant

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

Black, Not Hispanic

White, Not Hispanic

Asian/Pacific Islander

Hispanic

Other