

LIFT Senior Citizen Program/MATP Application

Part A TO BE COMPLETED BY CUSTOMER

SS# _____ - _____ - _____ NAME _____
ADDRESS _____ CITY/ZIP _____
PHONE _____ DATE OF BIRTH _____ / _____ / _____
IN CASE OF EMERGENCY CONTACT: _____
EMERGENCY ADDRESS _____ PHONE _____
Are you able to use the EMTA bus? _____ yes _____ no
Do you use any of the following equipment: _____ cane _____ crutches _____ walker
_____ wheelchair: If yes, can you transfer with minimal assistance? _____
_____ other (please specify) _____

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 .

If you live within ¼ mile of a bus route this application MUST be signed in Part B by your physician or a Social Service Agency to qualify for LIFT services.

Part B TO BE COMPLETED BY CERTIFYING AGENT

If the customer cannot use a EMTA bus, please provide a description of the functional disability and the extent of the disability ***in non-clinical terms***:

Is this disability temporary? _____ Does the customer require an escort? _____

I certify that, to the best of my knowledge, the above named person's functional disability, as stated above, requires paratransit transportation.

Name (Sign) _____ (Print) _____
Date _____ Phone _____ Address _____

Part C TO BE COMPLETED BY MEDICAL ASSISTANCE RECIPIENTS

This section is to be completed **ONLY** if you possess an ACCESS, Gateway or Med Plus card.

RECIPIENT # _____ CARD ISSUE # _____

OTHER ELIGIBLE HOUSEHOLD MEMBERS:

NAME	RECIP #	SS#	DOB

You may attach a separate sheet if necessary.
******APPLICATION CONTINUED ON REVERSE******

