# ELIGIBILITY FORM

## SECTION 1 - HOUSEHOLD IDENTIFYING INFORMATION

| NAME (Last, First, MI) | DATE OF BIRTH | TELEPHONE NUMBER |
|---|---|---|
| | | |

| ADDRESS (Street, City, Town, State, Zip Code) | COUNTY OF RESIDENCE |
|---|---|
| | |

## SECTION II - MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION

MATP FUNDING STATUS ▶ ☐ GROUP I ☐ GROUP II (D-00, D-05, B-00, PD-00, PD-21, PD-22, PD-29, TD-00, TD-11, TB-00)

| ACCESS CARD INFORMATION ▶ | RECIP NUMBER | SOCIAL SECURITY NUMBER | CARD ISSUE NO. |
|---|---|---|---|
| | | | |

| EVS ELIGIBILITY INFORMATION | | | | | |
|---|---|---|---|---|---|
| | DATE OF SERVICE | | | | |
| | HEALTH CARE BENEFIT CODE | | | | |
| | PROGRAM STATUS CODE | | | | |
| | CATEGORY OF ASSISTANCE | | | | |
| COMPLETED BY: | PLAN NAME | | | | |
| | HOTLINE NUMBER | | | | |
| | LOCK IN INFO | | | | |

## OTHER ELIGIBLE HOUSEHOLD MEMBERS

| NAME | RECIPIENT NUMBER | SSN | STATUS | DOB | GRP | MODE | FREQ/Wk-Mo | SPEC. NEED |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |

MODE KEY P = Public Transit S = Shared Ride A = Private Auto V = Volunteer O = Other (See Svc. Notes)

## SECTION III - DETERMINATION OF NEED FOR SERVICES

OTHER FUNDING SOURCES ▶ ☐ PENNDOT 203 ☐ DEPARTMENT OF AGING ☐ OTHER (Explain) _____

SPECIAL NEEDS ▶

MODE ▶

OTHER INFORMATION/ SERVICE NOTES ▶

## SECTION IV - ELIGIBILITY DETERMINATION DECISION

ELIGIBILITY STATUS ▶ ☐ ELIGIBLE ☐ INELIGIBLE | DATE CLIENT NOTIFIED ▶ | DATE ELIGIBILITY DETERMINED ▶

INELIGIBLE (Explain)

## SECTION V - AFFIRMATION OF INFORMATION

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.

| SIGNATURE OF CLIENT OR DESIGNEE | DATE SIGNED* | SIGNATURE OF INTERVIEWER | DATE SIGNED* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

EXHIBIT 2