



Dear rabbittransit HSDF Consumers:

Thank you for applying for the HSDF program. As required by the state, it is necessary that you provide rabbittransit with a copy of two of the following proof of citizenship documentations when applying for the HSDF services:

- Birth Certificate
- Social Security Card
- Drivers License
- Passport
- State Id
- School ID (children under 18)
- Access Card

Please feel free to contact our office at (717) 845-7553 with any questions or concerns

Thank you.



# HUMAN SERVICES DEVELOPMENT FUND ADULT SERVICES ELIGIBILITY FORM

## SECTION I—IDENTIFYING INFORMATION

Name of Applicant (Last, First, Middle Initial)

Address (Street, Road, Avenue)

City

State

Zip Code

County

Telephone Number

**FAMILY COMPOSITION** (If the space below is insufficient, list additional family members on a separate sheet of paper.)

Name Last, First, Middle Initial	Relationship to Applicant	Birthdate Month   Day   Year	Gender	Total Family Size:
SELF				Total Monthly Gross Income:
				Less Medical Expenses:
				Family Adj. Monthly Gross Income:
Specific Source Income	Monthly Gross Income	Explanation		

## SECTION II-SERVICE INFORMATION

Special Needs/Disability

Date Requested

## SECTION III-AFFIRMATION 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. 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 UNDER THE HUMAN SERVICES DEVELOPMENT FUND.

Signature and Date of Applicant or Person Acting on Applicants Behalf

Signature and Date of Interviewer

## SECTION IV-ELIGIBILITY FOR OFFICE USE ONLY

### NEED FOR SERVICE

Age Requirement?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does this applicant meet all applicable need criteria?	<input type="checkbox"/> YES <input type="checkbox"/> NO
County Resident?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Does applicant possess ACCESS card? Call EVS to determine 1-800-766-5387	<input type="checkbox"/> YES <input type="checkbox"/> NO RECIP. # DATE:	Is applicant's service need documented in client record?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Verification Entered: Health Care Benefits Category Program Status	HCB # C: PS:	Written documentation must be maintained in the Client Record to establish that the client needs the service, and that all applicable criteria, categories or conditions of the need are met.	
Eligible of HSDF per EVS?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Date Eligibility Determined	Eligibility Explanation:	Determined By	
Eligibility Status <input type="checkbox"/> Eligible <input type="checkbox"/> Ineligible		Applicant Notified-Date	Redetermination Date





Doctor Verification for Curb to Curb Service:

We are asking you to provide information regarding your ability to use the **rabbittransit** system. MATP requires **rabbittransit** to provide the least costly mode of service to an individual. The information you provide will allow us to better evaluate your request and provide the most appropriate level of service. Thank you for your cooperation in this matter.

PLEASE NOTE: This allows **rabbittransit** to assist those with disabilities that prevent them from accessing regular public transportation, not persons who find it uncomfortable or difficult to get to and from the bus stop.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

- Can the above names person ride a city bus to travel? YES \_\_\_\_\_ NO \_\_\_\_\_  
If you answered NO, please state why?

\_\_\_\_\_

- What is the disability that prevents this person from riding **rabbittansit's** fixed fare route?

\_\_\_\_\_

- Is the disability going to last longer than 12 months? YES \_\_\_\_\_ NO \_\_\_\_\_  
If you answered NO, please give a date for expected duration of the disability?

\_\_\_\_\_

- In your opinion, how many blocks can this person walk in blocks?

\_\_\_\_\_

- Do this person require an escort to travel? YES \_\_\_\_\_ NO \_\_\_\_\_  
If you answered YES, please state how this escort assists this person.

\_\_\_\_\_

\_\_\_\_\_

Physician's signature \_\_\_\_\_

Physician's name \_\_\_\_\_

(PLEASE PRINT)

Physician's Address \_\_\_\_\_

Physicians's phone # \_\_\_\_\_ Fax # \_\_\_\_\_

