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 ELIGILITY FACTORS MAY BE REQUIRED TO DETERMINE ELIGBILITY 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? | ☐ YES ☐ NO | Does this applicant meet all applicable need criteria? | ☐ YES ☐ NO |
| County Resident? | ☐ YES ☐ NO | | |
| Does applicant possess ACCESS card? Call EVS to determine 1-800-766-5387 | ☐ YES ☐ NO<br>RECIP. #<br>DATE: | Is applicant's service need documented in client record? | ☐ YES ☐ NO |
| Verification Entered: Health Care Benefits Category Program Status | HCB #<br>C:<br>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? | ☐ YES ☐ NO | | |

| Date Eligibility Determined | Eligibility Explanation: | Determined By | |
|---|---|---|---|
| Eligibility Status<br>☐ Eligible ☐ 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_______________________________________________________________
Physicans's phone # ___________________________Fax #____________________________