POTTER COUNTY VETERANS MEDICAL TRANSPORTATION ELIGIBILITY ASSESSMENT

Recipient Identification

Last Name:	First Name:	Middle Initial:	SSN:	DOB:

Veteran ☐ Discharge must be Honorable or Under Honorable Conditions | Do you have your DD Form 214? ☐ Yes ☐ No | If no, are you a member of the American Legion or VFW? ☐ Yes ☐ No

Spouse ☐ Spouse must be legally married to the Veteran. | Widow/Widower ☐ Have you remarried since the Veterans Death? ☐ Yes ☐ No | Please submit marriage license with this application.

Phone #:	Cell Phone #:	Email:

Street Address:	City:	State:	Zip Code:

Emergency Contact:	Relationship:	Phone #:

General Transportation Assessment

Do you have a valid Driver's License ☐ Yes ☐ No | Do you have a vehicle that is legally registered, insured, and drivable? ☐ Yes ☐ No

Are you or another household member able to drive you (and/or other household members) to medical appointments? ☐ Yes ☐ No

If you checked "No" - Please explain below. (Supporting documentation will be required.)

Do you have access to a vehicle of a friend or relative? ☐ Yes ☐ No | Will your friend or relative take you to medical appointments? ☐ Yes ☐ No | If yes, local? ☐ Yes ☐ No Out of town? ☐ Yes ☐ No

If yes, name and address of friend or relative with vehicle.

If you do not have a vehicle or access to a vehicle, how do you get to other appointments, shopping, or other personal needs? Describe below.

Do you live in a nursing home? ☐ Yes ☐ No | Do you live in a personal care home? ☐ Yes ☐ No Does your care agreement include transportation? ☐ Yes ☐ No

Do you need an escort to assist with your transportation? ☐ Yes ☐ No | Will you need to travel with an interpreter? ☐ Yes ☐ No

Do you have a disability that requires special accommodation? ☐ Yes ☐ No

Assessment of Recurring Appointments

List known locations for needed medical services.	Estimated distance from home	Number of weeks per month	Check the days of the week transportation is needed.					Appointment times if known	Comments
			Mon.	Tue.	Wed.	Thu.	Fri.		
			☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐		
			☐	☐	☐	☐	☐		

Mobility Assessment

Nature of Disability (Check all that apply)		Use of Mobility Aid (Check all that apply)		Is the use of this mobility aid temporary?		If temporary, date need will end	Comments and Descriptions
Mobility Disability	☐	Manual Wheelchair	☐	☐ Yes	☐ No		
Hearing Disability	☐	Motorized Wheelchair	☐	☐ Yes	☐ No		
Visual Disability	☐	Scooter	☐	☐ Yes	☐ No		
Cognative Disability	☐	Oversized Wheelchair	☐	☐ Yes	☐ No		
Behaviorial Health	☐	Walker	☐	☐ Yes	☐ No		
Gross Obesity	☐	Crutches	☐	☐ Yes	☐ No		
Other	☐	Braces	☐	☐ Yes	☐ No		
		Service Animal	☐	☐ Yes	☐ No		
		Other (Describe)	☐	☐ Yes	☐ No		

Is your wheelchair greater than 30" in width, 48" in length, measured 2 inches above the ground?
Does your wheelchair weigh no more than 600 pounds when occupied? ☐ Yes ☐ No ☐ Not Applicable

Can you transfer to a seat? ☐ Yes ☐ No Do you need assistance to transfer to a seat? ☐ Yes ☐ No

Signature

I understand the purpose of this evaluation is to help determine eligibility for medical transportation for me. I understand that the information about any disability contained in this application will be kept confidential and shared only with professionals involved in evaluating my eligibility. I hereby certify, 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 the Director, Potter County Veterans Affairs. I understand documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and giving knowingly false statements is a criminal offense. I understand that I have a right to request a Potter County Veterans Affairs fair hearing if benefits are denied. This affirmation statement covers all attachments required for the determination of eligibility.

Veterans utilizing this transportation program are not eligible for VA Reimbursement of Travel Expenses per VA guidelines.
By signing this form, I hereby acknowledge and affirm my responsibilities regarding this no-cost transportation benefit.

Print Application

Signature of Veteran, Surviving Spouse or Legal Representative

Date Signed

Mail application to: Potter County Veterans Medical Transportation Program
1 North Main Street, Suite 107, Coudersport, PA 16915

FOR OFFICE USE ONLY

Eligible: ☐ Yes ☐ No	Eligibility Date:	Approved By:	
Recipient Notified: ☐ Yes ☐ No	Date Notified:	Notified By:	
Application: ☐ On-line ☐ Mailed ☐ In-person	Date Application Sent:	Date Application Returned:	Received By:
Application Scanned & Emailed To PCHS ☐ Yes ☐ No		Date Sent:	Sent By:
Notes:			