pennsylvania
DEPARTMENT OF HEALTH

CHRONIC RENAL DISEASE PROGRAM (CRDP) TRANSPORTATION PROGRAM APPLICATION

All sections of this application must be completed to be processed. Please print using blue or black ink.

LAST NAME:	FIRST NAME:	M.I.:
CRDP RX#:	TELEPHONE #:	
STREET ADDRESS:		APT. #:
CITY:	STATE/ZIP CODE:	COUNTY:

Are you receiving benefits from the Department of Public Welfare's Medical Assistance (MA) Program (commonly referred to as ACCESS)? ☐ YES ☐ NO If yes, provide MA ID number: _____ Effective date: _____

If you are enrolled in MA (ACCESS), are you enrolled in the Medical Assistance Transportation Program (MATP)? ☐ YES ☐ No

If no, did you apply for MATP? ☐ YES ☐ NO If yes, when did you apply? _____

Were you denied enrollment in the MATP? ☐ YES ☐ NO If yes, explain:_____

Do you live in a nursing home? ☐ YES ☐ NO	Do you live in a personal care home? ☐ YES ☐ NO

If you live in a nursing home or a personal care home, is transportation provided to and from dialysis? ☐ YES ☐ NO

ASSESSMENT OF NEED

1. Do you have a valid driver's license? ☐ YES ☐ NO (If no, skip to question #4.)
2. Do you have a vehicle that is legally registered, insured and drivable? ☐ YES ☐ NO (If no, skip to question #4.)
3. Are you able to drive yourself to and from dialysis? ☐ YES ☐ NO If no, explain: _____

   _____
4. If you do not have a vehicle or are not able to drive to and from dialysis, do you live in an area where public transportation (bus/taxi/commuter rail system) is available? ☐ YES ☐ NO (If no, skip to question #6.)
5. If you answered yes to question #4, is the public transportation adequate to meet your needs of getting to and from dialysis?

   ☐ YES ☐ NO If no, please explain: _____
6. If you are not able to drive and public transportation is not available or is not adequate to meet your needs of getting to and from dialysis, are you able to use the county transportation or shared ride program to travel to and from dialysis?

   ☐ YES ☐ NO If no, please explain: _____
7. If you do not drive, or do not have access to adequate public transportation, or are not able to use the county transportation or shared ride program, how are you currently traveling to and from dialysis?

   _____

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8. Do you have a disability that requires a special mode of transportation? ☐ YES ☐ NO (If no, please go to the Transportation Information Section of the application.)

9. If you answered yes to question 8, please check all that apply:

☐ Mobility disability ☐ Visual disability ☐ Other (explain)_____

10. Please check every mobility aid you use and if the use is temporary:

Mobility Aid	Check if you use this mobility aid	Is the use of this mobility aid temporary?	Date temporary need will end	Comments and description
Manual wheelchair	☐	☐ YES ☐ NO		
Motorized wheelchair	☐	☐ YES ☐ NO		
Scooter	☐	☐ YES ☐ NO		
Oversized wheelchair	☐	☐ YES ☐ NO		
Walker	☐	☐ YES ☐ NO		
Crutches	☐	☐ YES ☐ NO		
Leg braces	☐	☐ YES ☐ NO		
Other (Please describe)	☐	☐ YES ☐ NO		

TRANSPORTATION INFORMATION

1. What mode of transportation are you applying for?

☐ RT110 – Public transportation (bus, taxi, commuter rail system, or county transportation/shared ride reduced fare programs that include transportation via a county/shared ride wheelchair van).

☐ RT130 – Non-emergency ambulance (a vehicle specifically designed, constructed, equipped and intended to be used for the purpose of transporting and providing non-emergency medical care to patients while in transit. Such services will be provided by a trained medical person.)
NOTE: If you select the mode of non-emergency ambulance, the Medical Certification Section of the CRDP transportation program application must be completed by your attending dialysis physician. In any case in which some means of transportation other than a non-emergency ambulance could be used without endangering your health, whether or not such other transportation is actually available, you will not be approved for non-emergency ambulance.

☐ RT140 – Invalid coach (private wheelchair van that is not part of a county transportation/shared ride reduced fare program)
NOTE: If you select the mode of invalid coach, you must provide documentation that the county transportation/shared ride program is not able to transport you to and from dialysis, or medical documentation from the dialysis physician that there is a severe medical need that prevents the use of county transportation/shared ride, along with a printout showing the mileage from your residence to your dialysis facility.

2. What days of the week do you go to dialysis? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

3. What dialysis facility do you go to? _____

4. What is the exact address for the dialysis facility you use? _____

_____

5. Name of social worker at dialysis? _____ Social worker telephone #: _____

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6. How many miles (one way) is it from your home to the dialysis facility? _____

7. Is this the closest dialysis facility to your home? ☐ YES ☐ NO

   If no, please explain why you do not utilize the facility closest to your home: _____

8. What is the name of the transportation company you will be using to transport you to and from dialysis?

_____

CRDP CARDHOLDER CERTIFICATION AND RELEASE

By signing, I understand my signature attests that the information provided on the CRDP Transportation Program Application is accurate, true and complete to the best of my knowledge. I further understand that:

A. I am acknowledging that all other transportation resources have been explored before I applied for this service.
B. I am acknowledging this service may not be used only as a convenience and that I am applying for the least expensive mode of transportation I am able to utilize.
C. I am acknowledging I must report any changes in circumstances immediately to the CRDP.
D. I am authorizing my medical representative to release any and all information required by the CRDP regarding my medical condition for the purpose of determining the appropriate method of transporting me to and from dialysis and my eligibility for this service.
E. The CRDP will keep all information contained in this application confidential, and it will only be shared with individuals involved in evaluating my eligibility.
F. Any person who submits a false or fraudulent claim of application to the CRDP for transportation services, or who assists another in the submission of a false or fraudulent claim or application, or who claims and receives duplicate or unwarranted benefits, may be subject to legal action which could include the loss of benefits under this or other commonwealth programs, the requirement to reimburse unwarranted benefits, and/or any appropriate criminal charge, which may include a charge under 18 Pa. C. S. Section 4904 relating to unsworn falsification to authorities.
G. The CRDP may refer me to another agency to obtain transportation benefits, if appropriate.
H. The Commonwealth of Pennsylvania shall be held harmless from all losses, damages, expenses, claims, demands, suits and actions brought as a result of any act committed by the vendor in performing the work of the CRDP transportation program, including transporting me from my place of residence to the dialysis center and from the dialysis center to my place of residence.

CRDP Cardholder's signature: _____Date: _____

APPLICATION INSTRUCTIONS

- This application must be submitted, via fax or mail, to the appropriate CRDP transportation provider upon completion. The CRDP transportation providers are:
  - National Kidney Foundation (covering western Pa. and the Delaware Valley)
    - Phone: 412-261-4115 Fax: 412-261-1405
  - Kidney Foundation of Central Pennsylvania (covering central Pa. and northeastern Pa.)
    - Phone: 717-652-8123 Fax: 717-671-9444

- The CRDP transportation providers must submit this application to the Department of Health within **15 business days** of the CRDP cardholder's signature. Therefore, it is important to submit this application to the CRDP transportation provider immediately after completion.
- If approved for the CRDP transportation program, the date of eligibility will be the date the CRDP transportation application is signed. In addition, if approved, a yearly renewal will be required, and the CRDP cardholder will

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receive a renewal application approximately two months prior to their eligibility end date.

- The CRDP transportation program is intended to assist with the cost of the CRDP cardholder's transportation costs; it is not intended to provide full reimbursement for all costs associated with transportation. If the rates on the CRDP transportation fee schedule do not fully cover the cost of the CRDP cardholder's transportation costs, the CRDP cardholder is responsible for the remainder of the transportation costs.

MEDICAL CERTIFICATION SECTION

This medical certification section must be completed by the attending dialysis physician if the CRDP cardholder has selected non-emergency ambulance (RN 130) as the requested mode of transportation. **Note: In any case in which some means of transportation other than a non-emergency ambulance could be used without endangering the CRDP cardholder's health, whether or not such other transportation is actually available, the CRDP cardholder will not be approved for non-emergency ambulance.**

1. Is the individual listed on this application bed-confined, defined as: the individual is unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair? ☐ YES ☐ NO

2. If no, does this individual have any of the below medical conditions:
   - ☐ Requires restraints to prevent harm and/or injury to self or others
   - ☐ Requires cardiac monitoring
   - ☐ Requires continuous oxygen monitoring by trained staff
   - ☐ Has to remain immobile because of a fracture
   - ☐ Is ventilator dependent
   - ☐ Requires continuous IV therapy

By signing, I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical record of the individual. I understand that providing false or misleading information could result in prosecution allowed by the laws of the Commonwealth of Pennsylvania.

Physician's name (please print):_____

Physician's address (please print): _____

City:_____ State:_____ Zip code:_____ Telephone: _____

Physician's signature:_____ Date:_____

THIS SECTION IS TO BE COMPLETED BY THE DEPARTMENT OF HEALTH TRANSPORTATION PROVIDER

Provider name: _____

By signing this document, I acknowledge that I have reviewed the CRDP application for accuracy and completeness, that all required supporting documentation is attached for the mode of invalid coach if applicable, and that, if applicable, the medical certification section is completed for the mode of non-emergency ambulance.

Provider signature:_____Date:_____ Telephone: _____

FOR DEPARTMENT USE ONLY:
Approved mode of transportation: _____ Transportation eligibility begin date: _____
Date approved: _____ Initials of approver: _____Transportation eligibility end date: _____