pennsylvania
DEPARTMENT OF HEALTH

CHRONIC RENAL DISEASE PROGRAM (CRDP)
Enrollment Application for Transportation Services

All sections of this application must be completed to be processed. ***Please Print using Blue or Black Ink.***

PATIENT'S LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH

PATIENT'S STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY	PATIENT'S TELEPHONE NUMBER

Are you currently enrolled in the Chronic Renal Disease Program? ☐ YES (If yes, complete below information) ☐ NO

CRDP CARDHOLDER ID_____ Coverage dates:_____

Are you receiving benefits from Department of Public Welfare's Medical Assistance (MA) Program? (Commonly referred to as ACCESS)

☐ NO ☐ YES If yes, provide MA ID Number: _____ Effective Date: _____
If no, was an application for MA filed? ☐ NO ☐ YES If yes, date application filed:_____

If you are enrolled in MA (ACCESS), are you enrolled in the Medical Assistance Transportation Program (MATP)? ☐ NO ☐ YES
If no, was an application for MATP filed? ☐ NO ☐ YES If yes, date application filed:_____
Were you denied enrollment in the MATP? ☐ NO ☐ YES If yes, explain:_____

Do you have any other insurance? ☐ NO ☐ YES If yes, provide policy information: _____

How will you be transported? ***NOTE: PERSONAL AUTO IS <u>NOT</u> AN ACCEPTABLE TRANSPORTATION MODE.***

☐ RT100 County Transportation System or Shared Ride Program

☐ RT120 Commercial Transportation Service (bus, taxi, commuter rail system)

☐ RT130 Non-emergency ambulance
<u>NOTE:</u> If you select this mode of transportation the Medical Certification Section on the next page, <u>must be completed by your attending dialysis physician</u>

☐ RT140 Invalid Coach (Wheelchair Van, Ambulate Van, Private Wheelchair Van)
<u>NOTE:</u> If you select this mode of transportation the Medical Certification Section on the next page, <u>must be completed by your attending dialysis physician</u>

By signing, I understand my signature attests that the information provided on the Application for CRDP Transportation Services is accurate, true, and complete to the best of my knowledge. I am aware that this service cannot be used only as a convenience. I further understand that:

A. 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.
B. The CRDP may refer me to another agency to obtain transportation benefits, if appropriate.
C. 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.

Patient's Signature: _____Date: _____

CRDP Cardholder ID: _____

MEDICAL CERTIFICATION SECTION: This medical certification section must be completed by the attending dialysis physician if the patient has selected either of the following modes of transportation: Non-emergency ambulance (RN 130) or Invalid Coach (RN140).

Medical Certification: By signing, I certify this patient's physical condition is such that due to bed or wheelchair confinement they cannot operate an automobile **OR** be transported **without** special assistance to and from the Dialysis Treatment Facility.

For this reason, I recommend the patient be transported by the following mode: ☐ Non-emergency Ambulance ☐ Invalid Coach

Reason (Check all that apply) ☐ Severe arthritis ☐ Paralysis ☐ Paraplegia or quadriplegia ☐ Amputated lower limb(s)

☐ Hip or leg fracture (s) ☐ Other (please specify)_____

Specify the length of time this mode of transportation will be required:_____

Physician's Name (Please Print):_____

Physician's Address (Please Print): Street Address:_____

City:_____ State:_____ Zip Code:_____ Telephone: _____

Physician's Signature:_____ Date:_____

THIS SECTION IS TO BE COMPLETED BY THE PATIENT'S SOCIAL WORKER AT THE DIALYSIS FACILITY

Is the patient a resident of an extended care facility or a rehabilitation center? ☐ NO ☐ YES

Have all other transportation resources been investigated for this patient prior to applying for CRDP Transportation Services including: Family, Friends, American Disabilities Act Funding, Veterans Administration, Area Agency on Aging, Social Service Agencies, Service Clubs, Religious Organizations, and Other Community Resources? ☐ NO ☐ YES

By signing this document, I acknowledge that I have assisted in the completion of this portion of the application and I make the following certifications: I have read the application carefully, and all patient information made on this application is true, accurate and complete to the best of my knowledge.

I understand that any person who submits a false or fraudulent claim or application to the CRDP for transportation services, or who assists in the submission of 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 requirements 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.

Social Worker's Name (please print):_____ Email Address: _____

Social Worker's Signature: _____Date:_____Telephone :_____

Dialysis Facility's Name (Please print): _____Telephone: _____

Dialysis Facility's Address (Please print): Street Address:_____

City:_____ State:_____ Zip Code:_____

Miles to Facility From Client's Residence (One Way):_____ Treatment Days Per Week (Circle all that apply): **M T W Th F S**

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

State Contractor's Name: National Kidney Foundation Serving Delaware Valley

Address: 3109 Forbes Avenue, Suite 101, Pittsburgh, PA 15216

Contractor's Signature:_____Date:_____ Telephone: 412-261-4115

8/1/11

FOR DEPARTMENT USE ONLY:
Transportation Eligibility Begin Date: _____ Approved Mode of Transportation: _____
Date approved:_____ Initials of Approver: _____