

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM ELIGIBILITY FORM

(complete all highlighted areas and return to FACT office along with a copy of your ACCESS card)

SECTION I-HOUSEHOLD IDENTIFYING INFORMATION								
Name (Last, First, MI)					Date of Birth		Telephone No.	
Address (Street, City, Town, State, Zip code)							County of Residence	
SECTION II-MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION								
MATP FUNDING STATUS								
<input type="checkbox"/> GROUP I <input type="checkbox"/> GROUP II (D-00, D-05, B-00, PD-00, PD-21, PD-22, TD-00, TD-11, TB-00)								
ACCESS CARD INFORMATION			RECIPIENT NUMBER		SOCIAL SEC NO.		CARD ISSUE NO.	
EVS ELIGIBILITY INFORMATION COMPLETED BY: _____			DATE OF SERVICE					
			HEALTH CARE CODE					
			PROGRAM STATUS CODE					
			CATEGORY OF ASSISTANCE					
			PLAN NAME					
			HOTLINE NUMBER					
			LOCK IN. INFO					
OTHER ELIGIBLE HOUSEHOLD MEMBERS								
NAME	RECIPIENT NUMBER	SSN	STATUS	DOB	GRP.	MODE	FREQ WK-MO	SPEC NEED
MODE KEY <input type="checkbox"/> P=Public Transit <input type="checkbox"/> S=Shared Ride <input type="checkbox"/> A=Private Auto <input type="checkbox"/> V=Volunteer <input type="checkbox"/> O=Other (see svc. notes)								
SECTION III-DETERMINATION OF NEED FOR SERVICES								
OTHER FUNDING SOURCES	<input type="checkbox"/> PENNDOT 203		<input type="checkbox"/> DEPARTMENT OF AGING			<input type="checkbox"/> OTHER (Explain) _____		
SPECIAL NEEDS								
MODE								
OTHER INFO SERVICE NOTES								
SECTION IV-ELIGIBILITY DETERMINATION DECISION								
ELIGIBILITY STATUS <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> INELIGIBLE				DATE CLIENT NOTIFIED		DATE ELIGIBILITY DETERMINED		
INELIGIBLE (Explain)								
SECTION V-AFFIRMATION OF 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 and that giving knowingly false statements is a criminal offense. 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.								
SIGNATURE OF CLIENT OR DESIGNEE				DATE	SIGNATURE OF INTERVIEWER			DATE SIGNED

(1) The transportation service may not be provided until:

- (i) The applicant has displayed a currently valid medical services eligibility card on which the applicant's name appears as a recipient, or the applicant's medical assistance eligibility has been verified by using a listing provided by the Department of Welfare;
- (ii) The applicant has declared that he/she is a permanent or temporary resident of the county where he/she applies for service;
- (iii) The applicant's Medical Assistance information number and category of assistance has been recorded for reporting purposes;
- (iv) The applicant has declared that he/she needs medical transportation;
- (v) The applicant has been determined to have a service need.

(2) The provider should advise the applicant that:

- (i) The applicant, under penalty of law, must provide the complete information to determine eligibility;
- (ii) When requested, the applicant must provide documentation of eligibility for medical assistance by displaying a currently valid ACCESS card, on which his/her name appears as a recipient.
- (iii) When requested, the applicant must attest in writing to the fact that the information he/she provided is true and correct.

2070.33 Validity of eligibility information provided by the applicants or clients:

- (a) If at any time the provider has cause to doubt the validity of the information given by the applicant/client, the provider may require documentation of the information.
- (b) The provider shall deny service or terminate from service and applicant or client who:
 - (1) Refuses to show a currently valid ACCESS card;
 - (2) Refuses to provide documentation requested to determine need;
 - (3) Refuses to attest to the validity of the information he/she has provided;
 - (4) Is found to be ineligible on the basis of the documented information.

Client Affirmation

To the best of my knowledge, the information I have given is true and correct and in accordance with the eligibility regulations of the Medical Assistance Transportation Program. Additionally, I have been given a copy of the Medical Assistance Transportation Operation Provisions.

Name _____

Date _____