MEDICAL ASSISTANCE TRANSPORTATION PROGRAM ELIGIBILITY FORM

(Complete all highlighted areas & return to FACT office with a copy of your ACCESS card)

SECTION 1-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

☐ GROUP I ☐ 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 → P=Public Transit S=Shared Ride A=Private Auto V=Volunteer O=Other (see svc. notes)

SECTION III-DETERMINATION OF NEED FOR SERVICES

OTHER FUNDING SOURCES	☐ PENNDOT 203	☐ DEPARTMENT OF AGING	☐ OTHER (Explain) _____
SPECIAL NEEDS			
MODE			
OTHER INFO SERVICE NOTES			

SECTION IV-ELIGIBILITY DETERMINATION DECISION

ELIGIBILITY STATUS ☐ ELIGIBLE ☐ 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, brochures and program information.

Name_____

Date_____