County Assistance Office Referral

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Medical Assistance
Transportation Program

Recipient Identification				
Last Name:	First Name:		Initial:	Date of Birth:
SSN:	MA Recipient #:		Phone #:	
Street Address:			Apartment #:	
City:	Municipality:	County:	State:	Zip:
Emergency Contact:		Relationship:	Phone #:	
Do this recipient speak English? ☐ Yes ☐ No	If no, what language is spoken?			
Will this recipient need to travel with an interpreter? ☐ Yes ☐ No				

The Medical Assistance (MA) recipient listed above has requested services not available or services unable to be provided through the Medical Assistance Transportation Program (MATP). MATP requires MA recipients to be referred to the County Assistance Office if the transportation request is determined to be exceptional transportation or for any other reason MATP cannot fulfill the transportation request.

Appointment Information				
Appointment Date:	Appointment Time:	Has the MATP verified this appointment is an MA eligible service? ☐ Yes ☐ No		
Provider or Practice Name:			Phone #:	
Street Address:				
City:	Municipality:	County:	State:	Zip:

Trip Information			
Is this a request delivery of "Exceptional Transportation" services? ☐ Yes ☐ No	Requested medical provider/service is outside operating area/hours of the MATP. ☐ Yes?		
Is this a non-emergency medically necessary (ambulance) transportation referral? ☐ Yes ☐ No	This need is: ☐ Permanent	☐ Temporary	

Please fully describe the reasons for this referral below:

MATP Referral Information
Referred by:
Telephone:
Date: