MEDICAL ASSISTANCE TRANSPORTATION PROGRAM: WAIVER REQUEST FORM				DATE	/ /
Name of Requestor / Contact		**Phone #**		**Requested Effective Date**	/ /
Requesting County(ies) / Corporation					
Please cite the requirement for which a waiver is being sought (from the "Scope of Services")					
Briefly describe the efficiencies and / or service enhancements that will result from the waiver					
Briefly describe the proposed alternative procedure					
Approximately how many consumers will be affected?		**How will they be affected? What change, if any, will result in the level of service?**			
Projected savings		**How were these savings calculated? Identify assumptions (i.e., fewer trips, shorter trips, shorter wait times)**			
How will the savings be used?					
Briefly describe the exception process for consumers who cannot be accommodated by the new requirement					
Timeframe Requested					