THE MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP) WRITTEN NOTICE FORM

DATE NOTICE ISSUED: _____

DATE AGENCY RECEIVED: _____

NAME: _____ **MAID:** _____
STREET: _____
CITY: _____ **ST:** ____ **ZIP:** _____

SECTION I - NOTICE

YOUR REQUEST FOR:
□ MATP Services
□ Transportation Services on: _____
□ Mileage Reimbursement on: _____
□ A Service Type Change

HAS BEEN:
□ Denied
□ Suspended
□ Terminated
□ Reduced

Effective _____ (15 days from issue date):

For the Following Reason (Please provide as much detail as possible):

_____
_____
_____

The PA Code or Regulatory Citation for the basis of this decision:

_____
_____
_____

SECTION II – APPEAL RIGHTS AND RESPONSIBILITIES

You have the right to appeal this decision and request a Fair Hearing through the Department of Human Services' (DHS) Bureau of Hearings and Appeals (BHA) if you disagree with the decision. The purpose of a Fair Hearing is to determine if the decision was based on a proper application of the law to your particular circumstances. You do not have the right to appeal a decision that is based on changes in Federal or State Law or Regulations which exclude you from eligibility for services or reduce the amount of services you currently receive.

To appeal this decision and request a Fair Hearing, you must complete the reverse side of this form and then mail or hand-deliver to _____(MATP Agency), located at _____(Address). The form must be postmarked or hand-delivered by _____ (30 calendar days from this Notice's Issue date).

If you are currently receiving MATP services and your form is postmarked or hand-delivered on or before _____ (10 calendar days from this Notice's Issue date), your services will be continued pending the outcome of your appeal. If your form is postmarked or hand-delivered after this date, services will be discontinued. Always Request A Date Stamp.

If you need assistance completing this form, have questions or do understand this decision and would like to discuss the decision. You may contact the person at the MATP Agency listed in **Section III**.

SECTION III – MATP AGENCY INFORMATION

_____
AGENCY NAME DATE TELEPHONE #

_____
AGENCY ADDRESS

_____
AGENCY REPRESENTATIVE PRINTED NAME AGENCY REPRESENTATIVE SIGNATURE

SECTION IV – FILING AN APPEAL

You have the right to file an appeal and request a Fair Hearing from the DHS' BHA within the time limits listed on the reverse side of this form in Section II.

To request a Fair Hearing, you must complete Section V and then mail or take this form to the MATP Agency listed in Section III. **Please note that the Hearing may be delayed if the form is not completed in full.**

You have the right to represent yourself or to have someone represent you at the Hearing. You may contact your local County Legal Services Office: _____ at ( ) _____ for information about obtaining a lawyer to represent you at the Hearing.

If you and/or your representative would like to meet with the Agency Representative to discuss the matter informally, to present information that might change the proposed action or to review all information that the Agency will introduce as evidence at the Hearing, please call the Agency Representative listed in Section III.

Please let the Agency Representative know if you do not speak the or have limited English language and need an interpreter. The DHS will arrange to have an official interpreter present at the Hearing at no cost to you. You may bring a friend or relative to assist you at the Hearing, but the interpreter provided by the DHS will be the official interpreter.

During the Hearing, an Administrative Law Judge will ask you to explain why you appealed and why you disagree with the decision of the MATP Agency. All facts will be reviewed, and a ruling made as to whether the decision of the MATP Agency is in accordance with the DHS' rules and regulations.

The BHA will hold the Hearing of your choice. If you prefer a telephone Hearing, but do not have a telephone and cannot use a friend's or relative's telephone, you may attend the Hearing at the MATP Agency listed in Section III.

Please indicate which type of hearing you prefer:

□ I prefer a telephone hearing.

□ I prefer a face-to-face hearing.

SECTION V – CONSUMER STATEMENT AND INFORMATION

PLEASE STATE THE REASON(S) FOR YOUR APPEAL

I WOULD LIKE A HEARING BECAUSE: _____

_____

_____

_____

_____

Please print your current address and telephone number, including area code ►

_____

_____(___)_____

PHONE NUMBER

Representative's name, address and telephone number. ►

_____

_____(___)_____

PHONE NUMBER

_____ _____

SIGNATURE OF CONSUMER DATE

_____ _____

SIGNATURE OF CONSUMER'S REPRESENTATIVE DATE

Issuing Agency Must Retain One (1) Copy and Issue Two (2) Copies to the Consumer

IF THIS WRITTEN NOTICE FORM IS APPEALED, SEND THIS APPEAL TO:

Department of Human Services / OMAP / MATP

8th Floor Commonwealth Tower / P.O. BOX 2675, Harrisburg, PA 17105-2675