MEDICAL ASSISTANCE TRANSPORTATION PROGRAM
WRITTEN NOTICE FORM

NAME: _____
ADDRESS: _____
_____

THIS NOTICE WAS MAILED OR HAND DELIVERED TO YOU ON: _____

SECTION I - NOTICE

THIS IS TO NOTIFY YOU YOUR REQUEST:

- ☐ For MATP Services
- ☐ For Transportation Services on: _____
- ☐ For Mileage Reimbursement on: _____

HAS BEEN:

- ☐ Denied
- ☐ Terminated Effective: _____
- ☐ Reduced or Service Type Change Effective Date: _____

For the Following Reason: _____

_____

The PA Code or the MATP Standard and Guidelines citation for the basis of this decision is/are:

_____

_____

SECTION II - APPEAL RIGHTS AND RESPONSIBILITIES

You have the right to appeal this decision and request a Fair Hearing through the Department's Bureau of Hearings and Appeals 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 (See Section IV). You do not have the right to appeal a decision that is based on changes in Federal or State law or Regulations which now exclude you from eligibility for service or reduce the amount of service you may receive.

To appeal this decision and request a Fair Hearing you must complete the reverse side of this form. Then, you must mail or hand-deliver this form to: _____ . (MATP Agency) located at: _____ .

Appeals must be postmarked or hand-delivered by: _____ , which is thirty (30) calendar days following the date this notice is mailed or hand-delivered to you.

If you are currently receiving service and your form is postmarked or hand-delivered on or before: _____ (10 Days) your service will be continued pending the outcome of your appeal. If your form is postmarked or hand-delivered after this date, service will be discontinued.

You may contact: _____ at _____ if you need assistance filling in your request for a Fair Hearing, or if you do not understand this decision or would like to meet with a representative of our agency.

SECTION III - MATP AGENCY INFORMATION

AGENCY NAME: _____

AGENCY ADDRESS (Street, City, State, Zip Code):

_____

_____	_____	_____
Agency Representative Signature	**Date**	**Telephone Number**

MATP Form, WN-100
(Revised 2/1/2017)

SECTION IV - FILE AN APPEAL

RIGHT TO AN APPEAL AND TO A FAIR HEARING

You have the right to file an appeal within the time limits specified on the other side of this form and request a Fair Hearing from the Department of Human Services.

In order to request a Fair Hearing, you must do the following:
(1) Provide your reason(s) for the appeal in the space provided below.
(2) Provide your telephone number; including area code in the space provided.
(3) Provide your address.
(4) Mail or take this form to the address of the agency specified in Section III. Always request a date stamp.

You have the right to represent yourself or to have anyone represent you. You can contact your local County Legal Services office, _____ at _____ if you want information about obtaining a lawyer to represent you at a hearing.

Before the scheduled hearing takes place, your or your representative has the right to examine all information which the agency will introduce as evidence at the hearing.

If you and your representative would like to meet with the service provider agency staff to discuss the matter informally or to present information which might change the proposed action, please call the agency representative specified in Section III.

If you need an interpreter at the hearing because you do not speak English or because you have limited understanding of English, the Department will arrange for an official interpreter at no cost to you. You may bring a friend or relative to assist you at the hearing, but the interpreter provided by the Department 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 by the MATP service provider agency. All facts will be studied and a ruling will be made as to whether the decision of the MATP service provider agency is in accordance with the Department of Human Services regulations.

The Bureau of Hearings and Appeals will hold a hearing for you either over the telephone or face-to-face. You may choose which type you want. If you do not have a telephone in your home and cannot get to one (for example, friend or relative's telephone) you may go to the telephone hearing at the service provider agency against which you filed the appeal.

Please indicate which type of hearing you want:

☐ I want a telephone hearing. ☐ I want a face-to-face hearing.

I WANT A HEARING BECAUSE:

(Please state a reason(s) for your appeal): _____

_____

_____

_____

YOUR MAILING ADDRESS AND TELEPHONE NUMBER ▶

_____

_____ _____

If someone will be representing you at the Hearing, please list their name, address, and telephone number. ▶

_____

_____ _____

I understand I will receive notification of the Hearing arrangements.

_____ _____
Signature of Consumer Date

_____ _____
Signature of Person Acting on Behalf of Consumer Date

To Appeal, you must Mail or Hand-Deliver this form to the Agency specified in Section III of this form (always request a date stamp).

MATP Agency, Copies to:
1. Recipient (Two Copies).
2. MATP Program Advisor upon notification of Appeal.
3. Bureau of Hearings and Appeals upon notification of Appeal.

Mail Appeals to: Department of Human Services (DHS)
Office of Medical Assistance Programs
Bureau of Hearings and Appeals
P.O. Box 2675
Harrisburg, Pa 17105-2675