Receipt of Program Information

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 #:	

Publication or Policy		Comments
Authorization to Release Information (MATP/PA-4)	☐ Received	
Welcome Brochure	☐ Received	
No-Show Policy	☐ Received	
Escort Policy	☐ Received	
Paratransit Pick-up Rule	☐ Received	
Paratransit One-Hour Rule	☐ Received	
Quarter Mile Rule	☐ Received	
Mileage Reimbursement Policy	☐ Received	
Urgent Care Policy	☐ Received	
Closest Methadone Clinic Regulation	☐ Received	
Transportation Access Standards	☐ Received	
Complaint Policy	☐ Received	
	☐ Received	

Rights and Responsibilities

RIGHT TO NONDISCRIMINATION

The Commonwealth of Pennsylvania prohibits discrimination on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, or sexual orientation.

RIGHT TO CONFIDENTIALITY

We will keep your information private. It will only be used to determine eligibility and type of transportation for which you qualify.

RIGHT TO A WRITTEN NOTICE

If we deny, change, suspend or stop benefits, we will give you a written explanation of why. You have 30 days from the mailing date of the notice to ask for a hearing.

RIGHT TO APPEAL

You have the right to ask for a Department of Human Services (DHS) hearing to appeal a decision if you believe it is unfair or incorrect, or if the MATP fails to act on your application. You may file the appeal at the Couny MATP office. If you appeal, you may also request a Conty agency conference before the hearing. At the hearing you may represent yourself, or someone else, such as a lawyer, friend or relative may represent you.

RESPONSIBILITY TO PROVIDE INFORMATION

You must give true, correct, and complete information. You must help in proving the information you give. Transportation may be denied if you fail to provide certain proof. If you cannot provide proof, you should ask the County MATP office to help you obtain it. If you are contacted by DHS or the Office of Inspector General, you must fully cooperate with those persons or investigators.

RESPONSIBILITY TO PROVIDE SOCIAL SECURITY NUMBERS

On application, you must provide a Social Security Number (SSN) for each person for whom you are applying. Your SSN will be used for identity and along with your MA Identification number to verify your Medical Assistance eligibility, category, and program code.

RESPONSIBILITY TO USE THE MATP LAWFULLY

Once you are determined eligible for the MATP, you may only use transportation (or receive mileage reimbursement) for services that are elligible MA covered medical services and are allowed by the MATP.

RESPONSIBILITY TO REPORT CHANGES

When receiving MATP services, you are required to report changes in your circumstances to the County MATP office as well as your caseworker at the County Assistance Office (CAO) or to the Statewide Customer Service Center. Types of changes reported would include a new address, new phone number, or new working hours that could affect the availability of an automobile if you receive mileage reimbursement. You are also required to report and verify any changes in mobility or physical ability that would affect your assigned mode of transportation. Failure to report required changes within the program guidelines could result in a loss of benefits, sanctions, or civil or criminal charges. You may report address and phone changes to the CAO in person, by phone, fax, mail or through a COMPASS account. You may also report changes to the Statewide Customer Service

Recipient Verification

By signing this form, I agree and attest I have received and understand the policy information provided as well as my rights and responsibilities outlined above. I understand that there are additional policies and procedures contained in the Medical Assistance Transportation Program Standards and Guidelines which determine the operation and scope of the MATP and by which I must also abide.

Signature of Applicant _____ Date Signed _____

If the MATP recipient or applicant is unable to sign this form (e.g. minor, disability, etc.) he/she may have someone sign and certify (below) on his/her behalf.

Signature of Designee _____ Date Signed _____ Relationship _____