MEDICAL ASSISTANCE TRANSPORTATION PROGRAM APPLICATION

The Pennsylvania Department of Public Welfare will provide reimbursement for public transportation or the use of a private auto for Medical Assistance recipients requiring transportation to and from a medical assistance reimbursable medical provider. **TransNet may provide paratransit service if the recipient has a functional disability, which prevents them from using public transit and a professional certifies this disability.** This form must be completed in its entirety and signed by the person eligible for Medical Assistance who is requesting transportation services or by his/her legal representative.

PLEASE NOTE: If you are 65 years of age or older you MUST also register for the Shared Ride Program in order to receive Medical Assistance Transportation services. Even though you are registered for the shared ride program, the entire cost of the trip will be covered by PaDot/Medical Assistance for eligible medical trips.

SECTION 1 - GENERAL

Last Name		First Name	MI	Date of Birth	Email Address	
Street Address				Apartment #	Social Security #	
City	County	State PA	Zip Code	Home Phone #		Cell Phone #
Emergency Contact Person		Relationship		Phone #		

SECTION 2 - GENERAL INFORMATION

Question	Check One: Yes	No	Question	Check One: Yes	No
Do you have a vehicle that you are able to drive? (an answer of **No** will be verified by the Office of the Inspector General)			Can you use the public transit system?		
Do you have family or friends who can transport you to your appointments? If "No", please explain below. (Supporting documentation will be required).			Are you registered with SEPTA Paratransit (CCT Connect)?		
			Do you have a physical or mental disability that prevents you from using public transit? If **yes**, you must submit a Verification of Disability form completed by your professional representative.		
Do you need an escort to assist with your transportation?			Do you live less than ¼ mile from a public transit stop?		
Do you require a language interpreter? If yes, please specify language spoken:			Do you live in a nursing home?		
Will you need to travel with an interpreter?			Do you live in a personal care home? If yes, does your care agreement include transportation?		
Do you have a disability that requires special accommodation? If yes, check all that apply.			Do you use a mobility aid? If yes, check all that apply.		
Mobility Disability Hearing Disability Visual Disability Cognitive Disability Behavioral Health Disability Gross Obesity Other, please specify:_____________________			Motorized Wheelchair Scooter Wheelchair Oversized Wheelchair Walker Crutches Braces Service Animal Other, please specify:___________________		
Is your wheelchair greater than 30" wide and 48" long (measured 2 " above the ground)?			Can you transfer to a seat?		
Does your wheelchair weigh more than 600 lbs. when occupied?			Do you need assistance to transfer to a seat?		

I hereby certify that to the best of my knowledge, the information contained herein is true, correct and complete. I agree to report any changes in circumstances immediately to TransNet. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that knowingly giving false statements is a criminal offense. I also give my consent to TransNet staff to contact
I am requesting transportation for the purpose of verifying that I have an appointment at that facility and that the appointment did in fact take place.
I agree to abide by all rules, regulations and procedures of the Medical Assistance Transportation Program and TransNet.
I understand that I am able to request a Department of Public Welfare fair hearing if transportation services are denied. This affirmation statement covers all attachments required for the determination of eligibility.

______________________________________ ____________________

Signature of Client/Parent/(Guardian signature required if applicant is under 18 years old.) **Date**

APPEAL NOTIFICATION:

If an individual has been informed that medical transportation services will be reduced, changed, suspended, refused, discontinued or delayed, the individual has the right to appeal to the Department of Public Welfare OMAP/MATP Fair Hearings, P.O. Box 2675, Harrisburg, PA 17105-2675. If an oral or written appeal is postmarked or received within fifteen (15) days of the mailing date of the notice of service denial, transportation benefits will continue without interruption pending the outcome of the appeal. A request for a fair hearing must be postmarked or received within thirty (30) days of the mailing date of the notice of service denial. At the hearing the individual will have an opportunity to explain the reason for the appeal.

Check One

Have you read the policies Included in the Medical Assistance User Guide located on our website? Yes No

Information in detail can be obtained by going to TransNet's website at:
http://www.suburbantransit.org/programs/medical-assistance-transportation-program

If you would like us to send you a copy of the Medical Assistance User Guide in the mail, please contact us by calling us at 215-542-7433, and press Option 5, to leave your name and address or e-mail us at: ride@suburbantransit.org

Please read the policies in the Medical Assistance User Guide carefully to ensure that you understand the policies before signing this document.

Name: ______________________________ Date: ______________

Signature of Applicant or Guardian

______________________________ Witness: ______________

Print Name of Applicant

FOR OFFICE USE ONLY - DO NOT COMPLETE BELOW THIS LINE

MA Recipient #		Card Issue #		Group #	Client ID #
MA Spend Down (circle one):		Y	N		
Date Initial Eligibility Determined:					
Date of Needs Assessment Review:					
Applicant Determined Eligible (circle one):		Y	N	Reason for Ineligibility:	
Eligible for:	Public Transit	Y	N		
	Mileage Reimbursement	Y	N		
	TransNet	Y	N		
Date Verification of Disability Received:					

Signature of Interviewer Date

Mail, e-mail or fax application to:

TransNet
980 Harvest Drive, Suite 100
Blue Bell, PA 19422
(215) 542-7433
Fax (215) 542-8877
ride@suburbantransit.org

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