

Medical Assistance Transportation Eligibility Form

Section I-HOUSEHOLD IDENTIFY INFORMATION

Name (Last, First, MI)		Date of Birth	Social Security #
Address		---	---
City	State	Zip Code	County of Residence
			Telephone Number #

Section II-MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION

Access Card Infor- _____	Access Card # _____	Do you have a vehicle in the household? YES NO
Or _____	Card Issue # _____	
Explain:		

Special Needs/Disabilities:

Specialized Transportation: Methadone Dialysis STAP- Name of Camp: _____
 After School Services Other _____

EMERGENCY CONTACT INFORMATION: Name _____ Relationship _____
 Address: _____ Phone # _____

Section III-AFFIRMATION OF INFORMATION

** 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 this Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Public Welfare hearing. This affirmation statement covers all attachments required for the determination of eligibility.

** I am authorizing that, in the event that the Service Provider must verify information regarding my trips from medical providers to which I am traveling, in order to comply with the Department of Public Welfare regulations, you have my permission to do so. The information will be held by only the Service Provider and its agents in the strictest confidence and will not be shared with any other agency, except the professionals from which we are receiving the information.

Signature: _____ Date Signed: _____

Section IV: *****FOR OFFICE USE ONLY*****

EVS ELIGIBILITY INFORMATION COMPLETED BY:	DATE OF SERVICE				
	HEALTH CARE BENEFIT CODE				
	PROGRAM STATUS CODE				
	CATEGORY OF ASSISTANCE				
	PLAN NAME				
	HOTLINE NUMBER				
	LOCK IN INFO				

OTHER ELIGIBLE HOUSEHOLD MEMBERS

NAME	RECIPIENT NUMBER	SSN	STATUS	DOB	GRP	MODE	FREQ WK-MO	SPEC. NEEDS

MODE KEY: P=PUBLIC TRANSIT S= SHARED RIDE A=PRIVATE AUTO V=VOLUNTEER O=OTHER (See Svc. Notes)

OTHER FUNDING SOURCE PENNDOT 203 DEPT OF AGING OTHER (EXPLAIN) _____

SPECIAL NEEDS

MODE

OTHER INFORMATION SERVICE NOTES

MATP FUNDING STATUS GROUP 1 GROUP 2 (D-00, D-05, B-00, PD-00, PD-21, PD-22, PD-29, TD-00, TD-11,

SECTION V- ELIGIBILITY DETERMINATION DECISION

ELIGIBILITY STATUS ELIGIBLE INELIGIBLE DATE CLIENT NOTIFIED _____ DATE ELIGIBILITY DETERMINED _____

INELIGIBLE (EXPLAIN):

STAFF SIGNATURE: _____ DATE: _____