

**ALLEGHENY COUNTY
 MEDICAL ASSISTANCE TRANSPORTATION PROGRAM -
 APPLICATION/ELIGIBILITY FORM
 1-888-547-6287**



SECTION I - HOUSEHOLD IDENTIFYING INFORMATION		
LAST NAME	FIRST NAME	TELEPHONE # ()
STREET NUMBER	ADDRESS	APT #
TOWNSHIP/BORO	STATE	ZIP
MAILING ADDRESS/P.O. BOX		
RECIPIENT & CARD ISSUE Number	SOCIAL SECURITY NUMBER	DATE OF BIRTH

SECTION II - MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/REVERIFICATION	
MATP FUNDING STATUS:	<input type="checkbox"/> GROUP I <input type="checkbox"/> GROUP II (D-00, B-00, PD-00, Pd21, PD-22, PD-29, TD-00, TB-00)
DATE OF SERVICE	
HEALTH CARE BENEFIT CODE	
CATEGORY OF ASSISTANCE	
PROGRAM STATUS CODE	
PLAN NAME	
REDETERMINATION DATE	

SECTION III - DETERMINATION OF NEED FOR SERVICE
SPECIAL NEEDS:
MODE OF TRANSPORTATION:
EMERGENCY CONTACT:
PARENT/GAURDIAN:

SECTION IV - AFFIRMATION OF INFORMATION

I hereby certify 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 fair hearing. This affirmation statement covers all attachments required for the determination of eligibility.

SIGNATURE OF CLIENT OR DESIGNEE:	DATE:	SIGNATURE OF INTERVIEWER:	DATE:

ALLEGHENY COUNTY
DEPARTMENT OF HUMAN SERVICES
OFFICE OF COMMUNITY SERVICES

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby give my permission to the Allegheny County Department of Human Services - Medical Assistance Transportation Program (MATP) to request information, as needed, from any medical facility, physician, dentist, hospital, clinic, pharmacy or purveyor of medical equipment regarding my need for and/or receipt of medical treatment, medical evaluation or purchase of prescription drugs or medical equipment.

I likewise give permission to any medical facility, physician, dentist, hospital, clinic, pharmacy or purveyor of medical equipment to provide such information to the Allegheny County Department of Human Services - Medical Assistance Transportation Program (MATP).

CLIENT AUTHORIZATION FOR MINOR CHILD TO TRAVEL
ALONE ON ACCESS PARATRANSIT VEHICLES OR PUBLIC TRANSPORTATION

(X=YES)

I hereby give my permission for my minor child age 13 - 17 to travel alone to and from medical appointments on ACCESS paratransit vehicles or public transportation.

I understand that I retain full responsibility for my child when traveling to and from medical appointments on ACCESS paratransit vehicles or public transportation.

I do not give my permission for my minor child age 13 -17 to travel alone to and from medical appointments on ACCESS paratransit vehicles or public transportation.

Client Signature:	Date:
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Address:

Telephone:

**TRANSPORTATION SERVICE WILL NOT BEGIN
UNTIL YOU SIGN AND RETURN
AN ELIGIBILITY FORM AND RELEASE OF INFORMATION FORM!**

Date Sent: _____