

Bucks County Transport, Inc.
Medical Assistance Transportation Program Application

The Pennsylvania Department of Human Services will provide reimbursement of public transportation or the use of a private auto for Medical Assistance recipients requiring transportation to and from a medical assistance reimbursable medical provider. Transportation with BCT may be available if the recipient has a functional disability, which prevents them from using public transit, and a medical professional certifies disability. Page 1 of this form must be completed in its entirety and signed by the person eligible for Medical Assistance who is requesting services. Page 2 of this form must be completed by a medical professional.

Section 1 - To be Completed By The Applicant

Please Print

Applicant's Name _____

M.A. ID # _____ **D.O.B.** _____

Street Address _____ **Apt #** _____

City _____ **Zip Code** _____ **Phone #** _____

Cell ph # _____

Emergency Contact _____ **Emergency Contact phone #** _____

Special Instructions or impairment: _____

Other Eligible Family Members

Name	D.O.B.	Social Security Number
_____	____-____-____	____-____-____
_____	____-____-____	____-____-____
_____	____-____-____	____-____-____

Do you own or have access to a motor vehicle? _____

Do you have a disability that prevents you from using public transportation if it is available? _____

PLEASE NOTE: PAGE 1 OF THIS APPLICATION IS FOR REIMBURSEMENT ONLY! IF TRANSPORTATION IS NEEDED, PAGE 2 MUST BE COMPLETED BY A MEDICAL PROFESSIONAL.

I hereby certify that to the best of my knowledge the information contained herein is true, correct and complete. I have read this entire application and understand it's contents and agree to abide by all rules, regulations and procedures of Bucks County Transport, Inc. and the Medical Assistance Transportation Program. I understand that I have the right to request a Department of Human Services Fair Hearing if transportation services are denied.

Signature of Applicant _____ **Date** _____ / _____ / _____

Disability Certification

To be completed by a medical professional

A medical professional is someone who has medical training, provides rehabilitative or therapeutic services, does cognitive assessments, or provides independent living and counseling services.

If transportation with BCT is requested, a medical professional must provide a explanation of functional disability that prevents the patient from using public transportation. Please be as specific as possible. (Keep in mind that SEPTA vehicles are lift-equipped and therefore can accommodate passengers in wheelchairs as well as disabled passengers. In addition, the Medical Assistance Transportation Program allows consumers to travel with an escort if necessary).

Passenger Name: _____ **M.A. ID #:** _____

Functional Disability: _____

I certify that to the best of my knowledge, due to the functional disability described above, my patient cannot use public transportation.

Is this functional disability permanent? Yes _____ No _____

If no, please specify approximately how long your patient will have a functional disability _____

Does this patient's disability require the assistance of an escort? Yes _____ No _____

Can this patient use public transportation with the assistance of an escort? Yes _____ No _____

Professional's Signature: _____

Professional's Name (Please Print) _____

Professional's Affiliation/Title: _____

License # if applicable _____

Telephone: _____

Date : _____

Section II Appeal Notification

If an individual has been informed that medical transportation services are going to be reduced, changed, suspended, refused, discontinued or delayed, the individual has the right to appeal to the Department of Human Services Bureau of Hearings and Appeals, P.O. Box 2675, Harrisburg, PA 17105. If an oral or written appeal is postmarked or received within ten (10) days of the mailing date of the notice of service denial, 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.

Return this form to:
Bucks County Transport, Inc.
P.O. Box 510
Holicong, PA 18928
(215) 794-5554
(215) 794-5564 (fax)