



### Medical Assistance Transportation Program (MATP) Application

The Pennsylvania Department of Human Services (DHS) will provide reimbursement of public transportation or the use of a private vehicle for Medical Assistance Receipts 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 the disability. Page 1 (one) of this form must be completed and signed in its entirety by the person eligible for Medical Assistance who is requesting services. Page 2 (two) of this form must be completed by the person's medical professional.

#### Section 1- Completed by Applicant

Applicant's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Home Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ State: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone #: \_\_\_\_\_

Special Instructions or Impairment: \_\_\_\_\_

#### Other Eligible Family Members:

Name:	Date of Birth:	Social Security #:
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 within 30 days by a medical/clinical professional.**

*I hereby certify that 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 of the rules, regulations and procedures of Bucks County Transport, Inc., and the Medical Assistance Transportation Program (MATP). I understand that I have the right to request a PA Department of Human Services Fair Hearing if transportation services are denied.*

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_