MEDICAL ASSISTANCE TRANSPORTATION PROGRAM
CLIENT AGREEMENT FORM

Please fill out both sides of this form.

FORM MUST BE SIGNED AND RETURNED WITHIN 30 DAYS OF REGISTRATION DATE OR SERVICE WILL BE SUSPENDED UNTIL SIGNED FORM IS RECEIVED IN OUR OFFICE

Name of Applicant	Social Security #	Date of Birth	Telephone #
Residence: (Street, Apt number, floor etc.)			Recipient/Access Card # (10 digits)
Mailing address: (if different from residence)	Health Plan	Health Plan #	Access Card Issue # (2 digits)
City, State, Zip Code	County of Residence		

Other Eligible Household Members: (Example: Spouse and Children)

Name	Social Security #	Date of Birth	Access Card# (10 digits)	Card Issue# (2 digits)	

Please list additional members on separate sheet of paper.

ELIGIBILITY DETERMINATION/VERIFICATION *[For Office Use Only]*

EVS Date: Eligible: Ineligible: Determined: Notified: Initials:

STATEMENT OF AFFIRMATION:

I hereby certify that to the best of my knowledge the information contained here is true and complete. I have read all the materials sent to me and I agree to follow the guidelines and regulations as explained. I further realize that failure to do so will result in service being denied. I agree to report any changes to Rover Community Transportation immediately. I understand that documentation of all eligibility factors may be required to determine eligibility or for auditing purposes and that knowingly making a false statement is a criminal offense. If service is denied I understand that I have a right to request a DPW Fair Hearing. This statement covers all attachments required for the determination of eligibility.

[For Office Use Only]

Signature of Client or Designee	**Date Signed**	For Chester County:	Date

RETURN COMPLETED AND SIGNED FORM TO:

ROVER Community Transportation

1002 S. Chestnut St., Downingtown, PA 19335

Fill out other side

PLEASE PROVIDE THE FOLLOWING INFORMATION:

(Managed Care Plan):		**Behavioral Health**	
Plan #:		Provider Name:	
Primary Physician Name:		Address:	
Primary Physician Address:		Phone #:	
City:	Phone #:	Provider MA #:	
Primary Dentist Name, Address, Phone #:		Other Doctors:	
Eye Care:			
Other Provider:			
Verified:	*Date:*	*Verified:*	*Date:*

1. Is Medical Assistance paying for your visits? Yes ____ No ____

2. Is your health care provider outside of Chester County? Yes ____ No ____

3. Do you live within ¼ mile of public transportation? Yes ____ No ____
   Is your doctor or medical facility within ¼ mile of public transportation? Yes ____ No ____

4. Do you have an automobile or access to an automobile that you can use? Yes ____ No ____

MATP Quarter-Mile Rule: If you live within ¼ mile of public transportation and your doctor is within ¼ mile of public transportation, the MATP will reimburse you for your public transportation fare. You will not be able to use Rover Community Transportation unless you have a medical reason why you cannot use the public transportation. Call the MATP Coordinator 1-877-873-8415 for a Special Needs Transportation form. If you have an automobile, MATP will reimburse you .12 cents per mile to and from your medical appointments. A Reimbursement Request form is included with your application packet.

5. Do you have any special needs, such as?
Use a Wheelchair Yes ____ No ____
Do you need a van with a lift? Yes ____ No ____
Visually Impaired Yes ____ No ____
Hearing Impaired Yes ____ No ____
Difficulty walking Yes ____ No ____
Do you need an Escort to go with you on your rides? Yes ____ No ____
If yes, please call and request an MATP Escort Application

Will you be going to a partial hospitalization program? Yes ____ No ____
If Yes, which one:

Thank you for answering these questions. All answers are confidential.
Service Information: [Below is for Office Use Only]

ROVER ____ Public Transportation ____ Mileage ____ Spec Need ____ Escort ____ Lift ____

Questions about the MATP Program call 877-873-8415 and ask for the MATP Coordinator.

Updated February 2013