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 1of 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 _____

Social Secutity # _____ - _____ - _____ **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** _____ / _____ / _____