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. Bucks County Transport is responsible for determining the least costly and most appropriate form of transportation for an MATP consumer.

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 #: _____

Do you use a mobility device: _____

_____

Please list any additional household members who may be eligible:

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

Do you own or have access to a reliable motor vehicle or have someone available that can transport you to your medical appointments daily? (friends or family) _____

Do you live within ¼ mile of a fixed route? _____

Are your medical appointments within a ¼ mile of a fixed route? _____

Do you have a condition that prevents you from using public Transportation if it is available? _____

***Please note if you answered yes to the above question, you would need to have a healthcare professional complete the disability form (page 2).**

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: _____