



To Medical Assistance Transportation Program Applicants:

The enclosed form is an application to determine your eligibility for the Medical Assistance Transportation Program (MATP).

If your physician requests ParaTransit service for you:

- Complete the Certification of Disability
- They must provide a brief explanation of the functional disability, which prevents you from using public transportation.
- MATP provides the **least costly, most appropriate** mode of service.

You cannot use MATP:

- If you need emergency ambulance transportation
- For non-medical trips such as for grocery shopping or for social activities
- To obtain medical care that is not covered by Medical Assistance.

The verification process can take up to **10 business days**. Once we determine your eligibility, you will receive written verification from Community Transit, notifying you which transportation mode you are approved for. To avoid delays, please make certain your form is **complete and legible**.

Any applications submitted without the required information will be returned to the applicant. **Please note: we cannot approve your application without your Physician's signature**. Applications returned without the Physician's signature will be registered for reimbursement. We will call to verify.

It is the applicant's responsibility to get their forms completed and to send them into our office.

Submit your application to:

**Community Transit of Delaware County
MATP
206 Eddystone Avenue
Suite 200
Eddystone, PA 19022
Fax: 610-490-3982
Email: generaladmin@ctdelco.org**

If you have any questions, please call us at 610-490-3975.

Thank you for your cooperation!

Revised 7/18/2017



Medical Assistance Transportation Program Application

SECTION I- Basic Information

Last:	First:	Middle Initial:	
Birth Date: / / Month Day Year	Social Security#	Recipient ID# (from ACCESS Card)	
Address:			
House Number and Street	Apt.#	City	Zip Code
Telephone#:	Cell Phone#:	Nearest Cross Street:	
Emergency Contact#:	Emergency Contact Name:	Relationship:	Email Address:

Check: YES or NO

SECTION II- Transportation Information

Do you have a vehicle that you are able to drive?	Yes	No
Do you use mass transit (SEPTA)?	Yes	No
Do you have family/friends who can take you to your appointments?	Yes	No
Are you registered with SEPTA Paratransit (CCT Connect)?	Yes	No
Do you live less than ¼ mile from mass transit (SEPTA) stop?	Yes	No
Do you have a SEPTA Reduced Fare Card?	Yes	No
Do you have a physical or mental disability that prevents you from using mass transit (SEPTA)? If yes, please have the Assessment of Needs Form completed by healthcare professional.	Yes	No

Section III- Authorization for Release of Information

55 Pa. Code § 2070.25 requires providers of medical services to give access to and allow the use and disclosure of information on applicants and clients to: Federal authorities, the Commonwealth, the Department, the County Commissioners or County Executive, and prime contractors or their authorized agents, if the information is necessary to the administration of the Medical Assistance Transportation Block Grant. I hereby authorize and request the disclosure to the Medical Assistance Transportation Program any information concerning eligibility, specific transportation requests, verification of an appointment, including dates and times, verification of cancelled or missed appointments, and verification that a medical service was received. This release also includes only medical information that is relevant to the mode of transportation required and to any limitations a medical condition or diagnosis would place on provision of transportation. It is understood that the information obtained will be used for purposes directly related to the Medical Assistance Transportation Program.

X

Applicant's Signature

Date

If applicant is unable to sign this form, he/she may have someone sign and certify on applicant's behalf (e.g., minor, disability)

X

Signature of Person Signing for Applicant

Date

How did you hear about our services? _____

Federal regulations require us to ask for your ethnicity. This information is for statistical purposes only and will be held in the strictest of confidence by Community Transit. The completion of this section is optional and it will not have any bearing on your eligibility, determination of mode, or any service you receive.

Please check the box below that best describes your ethnic/racial identity:

- | | | |
|---|--|--|
| <input type="checkbox"/> American Native | <input type="checkbox"/> Black, Not Hispanic | <input type="checkbox"/> White, Not Hispanic |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other |