# 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 FOR 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 #** | **Birth date** | **Access Card#** | **(office use) Client ID #** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***Please list additional members on separate sheet of paper.***

**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 could 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 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**
***Fax 484-593-0454***

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

| **(Managed Care Plan):** | | |
|---|---|---|
| Plan #: | | |
| Primary Physician Name: | | |
| Primary Physician Address: | | |
| City / Zip: | Phone #: | |

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 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 ____
   Can't see well Yes ____ No ____
   Hard of hearing 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

Thank you for answering these questions. All answers are confidential.

**[Below is for Office Use Only]**

Service Information:

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

***Questions about the MATP Program call 877-873-8415***
***And follow the prompts for Public Assistance Riders / Eligibility and Questions.***

**Rev. C May 2016**