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.

PROGRAMA DE TRANSPORTACION DE ASISTENCIA MEDICA
ACUERDO DEL CLIENTE

Favor de llenar ambros lados. Este formulario tiene que ser firado y entregado antes de que reciba el servicio

Nombre de solicitante	N de Seguro Social	Fecha de Nacimiento	N de telefono
Direccion Postal (Calle y/o Apartado):		N de recipient (10 digits)	
Direccion de su Residencia (si es deferente):	Health Plan	Health Plan #	N de Card Issue (2 digits)
Ciudad, Estado, Codigo Postal	Condado		

Otros Miembros Caseros Elegibles:

Nombre	N de Seguro Social	Fecha de Nacimiento	N de recipiente	(office use) Client ID #

Favor de alistar los miembros adicionales en una hoja adjuntada

Declaracion de afirmacion:
Yo,por estr medio, certifico que,segun mi entender, la informacion contenida aqui es verdadera y complete. Yo he leido todala material que me han mandado y yo declaro que seguire las guias y las regulaciones segun me las explicaron. Ademas me doy cuenta de que el dejar de hacerlo resultara en que nieguen el servicio. Me acuerdo reporter inmediatamente cualquier cambio de esta informacion el Departamento de los Servicios Humanos del Condado de Chester. Entiendo que pueden requerir la documentacion de todos los factores de elegibilidad para determiner mi elegibilidad o para el proposito de verificacion contable, y que el hacer declaraciones falas intencionalmente es un delito criminal. Si me niegan el servicio, yo entiendo que tengo el derecho de pedir una audiencia justa del Departamento de Bienestar Publico. Esta declaracion incluye todas las hojas adjuntadas requeridas para la deteminacion de su elegibilidad.

(For Office Use Only)

Firma del Cliente o de la Persona Designada	Fecha de Firma	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):		
N del Plan “Oak Tree”:		
Nombre de su doctor primario:		
Su direccion (N, calle):		
Ciudad:	N de telef:	

1. Paga sus visitas al doctor su tarjeta de Asistencia Medica? Si ____ No ____
2. Tendra que ir a un doctor, clinica u hospital afuera del Condado de Chester? Si ____ No ____
3. Vive usted menos de ¼ milla de transportacion publica? Si ____ No ____
   Esta su doctor o centro medico dentro de ¼ milla de transportatcion publica? Si ____ No ____
4. Tiene usted un carro que puede usar? Si ____ No ____

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5. Tiene usted algunas necesidades especiales? Por ejemplo (Marque las que le aplican):

   Uso una silla de ruedas Si ____ No ____

   No puedo ver bien Si ____ No ____

   No puedo oir bien Si ____ No ____

   Tengo dificultades al caminar Si ____ No ____

   Necesito un acompanante Si ____ No ____

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 ____

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