


DAUPHIN COUNTY MH/ID PROGRAM MATP POLICY AND PROCEDURE

Agency	<input checked="" type="checkbox"/> CCB	Policy No.	<u>18-01</u>
	<input checked="" type="checkbox"/> County	Effective Date	<u>May 9, 2018</u>
	<input type="checkbox"/> CAT	Revision Date	
	<input checked="" type="checkbox"/> Boyo/Other	Approved	

Title: MATP Eligibility Verification & Coordination Requirements

Policy: The Dauphin County MATP will assure that eligibility is confirmed and coordinated for all children and adolescents funded by MATP by the MATP eligibility provider, specialized child and adolescent transportation provider and Medical Assistance funded service providers.

Definitions:

MATP Standards and Requirements: The document published by the Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs, describing the responsibilities and requirements for the operation of the Medical Assistance Transportation Program.

MATP Eligibility Provider: The agency that is under contract with the Dauphin County MH/ID Program to determine MATP consumer eligibility and transportation modes used for Medical Assistance Transportation services.

Specialized Child and Adolescent Transportation Provider: The agency contracted by the Dauphin County MH/ID Program to provide MATP transportation to Specialized Child and Adolescent Program Services.

Community Program Providers: A community based Medical Assistance compensable service provider whose participant's transportation service is covered by MATP, such as Philhaven's Afterschool Program, NHS's Stepping Stones School Program and PPI's Partial Program and whose participants utilize a specialized child and adolescent transportation provider such as Boyo Transportation.

MATP Applicant: A consumer who is applying for any MATP service with the County, or its MATP Providers.

MATP Eligibility Form: The form established by MATP to determine a consumer's eligibility for MATP transportation (Attachment 1).

Authorization for Release of Health Care Information: The form established by the Dauphin County MATP Eligibility Unit to meet the State MATP requirement of medical appointment verification (Attachment 2).

MATP Consumer: An MATP consumer is any consumer who is registered and determined to be eligible for any MATP service with the County, or it's MATP Providers.

MATP Boyo Transportation Referral Form: The form required by the MATP Contracted Transportation Provider to obtain Program and Client information from the Community Program Provider to begin MATP funded transportation service for eligible consumers. (Attachment 3).

Weekly MATP Eligibility Verification Roster: The form required by the MATP Eligibility Unit to obtain Program and Client information from the Community Program Provider and to confirm on-going MATP eligibility on a weekly basis to assure coordination and continuing eligibility for transportation services for a MATP Client (Attachment 4).

Procedure:

I. Procedure for Referrals for NEW MATP Consumers to the MATP transportation service.

- A. The Community Program Provider must send a completed MATP Eligibility Form (Attachment 1) and an Authorization for Release of Healthcare Information Form (Attachment 2) to the MATP Eligibility Provider (CCB Inc.) to establish MATP Eligibility for program consumers needing MATP funded transportation by a Specialized Child and Adolescent transportation provider (Boyo).
- B. The Eligibility Provider verifies consumer eligibility and sends notification of results to the Community Program Provider and to the Specialized Child and Adolescent Transportation Provider (Boyo) within in 24 hours.
- C. To finalize the referral process and begin transportation, the Community Program Provider(s) then completes an MATP Boyo Transportation Referral Form (Attachment 3) that contains Program and Consumer Information necessary for transportation, and submits to the Specialized Child and Adolescent Transportation Provider (Boyo) to establish transportation services for the new consumer.
- D. The Specialized Child and Adolescent Transportation Provider (Boyo), then notifies the Community Program Provider & the consumer's parents of transportation start date and pick up times.

II. Procedure for coordinating ongoing MATP transportation eligibility for MATP consumers.

- A. All Community Program Providers utilizing the MATP Specialized Child and Adolescent Transportation Provider (Boyo) must send a Weekly MATP Eligibility Verification Roster (Attachment 4) listing all consumers needing transport in the upcoming week to the Eligibility Provider. This must be sent weekly no later than Friday by 12:00 noon and is to include all consumers in need of transportation in the upcoming week, whether or not they are new riders.

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- B. The Eligibility Provider determines eligibility of all consumers listed on the Weekly MATP Transportation Roster (Attachment 4) and contacts the MATP Specialized Child and Adolescent Transportation Service Provider (Boyo) and the Community Program Provider providing verification of both eligible and non-eligible consumers.
 - C. If a Community Program Provider does not forward the weekly roster to the Eligibility Unit as required, any consumer found to be ineligible for MATP subsequent to the failure to submit the required weekly roster, the Community Program Provider will be responsible for the cost of the ineligible consumer's transportation to the program. The Community Program Provider shall make payments directly to the Specialized Transportation Provider for any MATP ineligible trips provided.
- III. Procedure for terminating consumers attending a community program from MATP service.
- A. If an MATP consumer no longer needs transportation services to and from Program Provider services, the Community Program Provider must notify both the MATP Eligibility Provider and the MATP Specialized Child and Adolescent Transportation Provider (Boyo) with the transportation end date.
 - B. Upon receipt of the transportation cancelation, both the MATP Eligibility Provider and the MATP Specialized Child and Adolescent Transportation Provider (Boyo) will confirm receipt of the cancelation with the Community Program Provider who issued the cancelation.

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM ELIGIBILITY FORM

SECTION I – HOUSEHOLD IDENTIFYING INFORMATION

NAME (Last, First, MI)	DATE OF BIRTH	TELEPHONE NUMBER
ADDRESS (Street, City, Town, State, Zip Code)		COUNTY OF RESIDENCE DAUPHIN

SECTION II – MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION/RE-VERIFICATION

MATP FUNDING STATUS	<input type="checkbox"/>	GROUP I	<input type="checkbox"/>	GROUP II	(D-05, B-00, PD-00, PD-21, PD-22, TD-00, TD-11)
ACCESS CARD INFORMATION	RECIP NUMBER	SOCIAL SECURITY NUMBER		CARD ISSUE NO.	
EVS ELIGIBILITY INFORMATION	DATE OF SERVICE				
	HEALTH CARE BENEFIT CODE				
	PROGRAM STATUS CODE				
	CATEGORY OF ASSISTANCE				
COMPLETED BY:	PLAN NAME				
	HOTLINE NUMBER				
	LOCK IN INFO				

OTHER ELIGIBLE HOUSEHOLD MEMBERS

NAME	RECIPIENT NUMBER	SSN	STATUS	DOB	GRP	MODE	FREQ/Wk•Mo	SPEC. NEED

MODE KEY P = Public Transit S = Shared Ride A = Private Auto V = Volunteer O = Other (See Svc. Notes)

SECTION III – DETERMINATION OF NEED FOR SERVICES

OTHER FUNDING SOURCES	<input type="checkbox"/>	PENNDOT 203	<input type="checkbox"/>	DEPARTMENT OF AGING	<input type="checkbox"/> OTHER (Explain) _____
SPECIAL NEEDS	▶▶▶				
MODE	▶▶▶				
OTHER INFO./ SERVICE NOTES	▶▶▶				

SECTION IV – ELIGIBILITY DETERMINATION DECISION

ELIGIBILITY STATUS	<input type="checkbox"/>	ELIGIBLE	<input type="checkbox"/>	INELIGIBLE	DATE CLIENT NOTIFIED	DATE ELIGIBILITY DETERMINED
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DO YOU LIVE ¼ MILE (4 BLOCKS) OR LESS FROM BUS ROUTE SERVICES? CIRCLE YES OR NO

DO YOU OWN OR HAVE ACCESS TO A VEHICLE? CIRCLE YES OR NO

SECTION V – AFFIRMATION OF INFORMATION

I hereby certify that, to the best of my knowledge, the information contained herein is true, correct and complete. I agree to report any changes in circumstances immediately to this Service Provider. I understand that documentation of all eligibility factors may be required to determine eligibility correctly or for auditing purposes and that giving knowingly false statements is a criminal offense. I understand that I have a right to request a Department of Human Services fair hearing. This affirmation statement covers all attachments required for the determination of eligibility.

SIGNATURE OF CLIENT OR DESIGNEE	DATE SIGNED	SIGNATURE OF INTERVIEWER	DATE SIGNED

CENTER FOR COMMUNITY BUILDING, INC
3525 NORTH 6TH ST
HARRISBURG, PA 17110
717-232-7009 MATP NUMBER 717-232-9884 FAX NUMBER
1-800-309-8905 TOLL FREE NUMBER

DAUPHIN COUNTY
MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)

Authorization for Release of Health Care Information

I _____ hereby give authorization to the
(Name of Client) above organization.

(Address)

(Phone Number)

Health Care Providers

(Name of Provider)

(Address)

(Phone Number)

(Name of Provider)

(Address)

(Phone Number)

I understand that I am giving an authorization for the release of confidential medical appointment verification and that I may revoke this release at any time except to the extent that the person or organization that is to make the disclosure has already acted upon it.

Client or Guardian Date

Name of Client: _____

Health Care Providers

(Name of Provider)

(Address)

(Phone Number)

(Name of Provider)

(Address)

(Phone Number)

(Name of Provider)

(Address)

(Phone Number)

(Name of Provider)

(Address)

(Phone Number)

WEEKLY MATP TRANSPORTATION ROSTER

PROGRAM INFORMATION

START TIME:

END TIME:

DAYS CLOSED:

PROGRAM CONTACT:

CONTACT NUMBER:

PROGRAM NAME:

ADDRESS:

CITY, STATE, ZIP CODE:

TELEPHONE NUMBER:

DATE FORM COMPLETED:

SOCIAL SECURITY NUMBER

DATE OF BIRTH

START DATE

END DATE

EMERGENCY CONTACT

TELEPHONE NUMBER

CAREGIVER

CAREGIVER #

COMMENTS

FIRST NAME

LAST NAME

MA #