CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

CAO _____

MEDICAL TRANSPORTATION ALLOWANCE PAYMENT AGREEMENT

Please initial each line and sign and date below.

_____ I agree that I will use all money received for my Medical Assistance transportation to pay the provider for my transportation.

_____ I understand that I am responsible to use the transportation allowance to pay the provider.

_____ I agree to provide a receipt of this payment to the CAO within 14 days of receiving the transportation service.

_____ I understand that failure to provide verification may mean disqualification for future medical assistance transportation allowances.

_____ _____
CLIENT SIGNATURE DATE

_____ _____
CAO SIGNATURE DATE