pennsylvania
DEPARTMENT OF HUMAN SERVICES

TRANSPORTATION REFERRAL FORM

I. Referral to:

☐ County Assistance Office (CAO)	☐ Health Choices Managed Care Organization (HC-MCO)	☐ Community Health Choices Managed Care Organization (CHC-MCO)
Select One	Select One	Select One

II. Individual's Contact Information:

First Name		Last Name	
Date of Birth		MA ID	

Street Address	Apartment #	City	State
			Select

Zip Code	County	Phone Number
	Select One	

Responsible Party's Name	Responsible Party's Phone Number

Does the individual need specialized mode of transportation? ☐ No | ☐ Yes If yes, mode?_____

Does the individual need an escort? ☐ No | ☐ Yes

Does the individual need an interpreter? ☐ No | ☐ Yes If yes, what language?_____

III. Appointment Information:

Appointment Date	Appointment Time	Appointment Type	Recurring Appointment?
	Select		☐ Yes ☐ No

If Recurring – Day: Select One	Comments:

Provider Name	Street Address	City	State
			Select

Zip Code	Phone Number

IV. Trip Information:

What mode of transportation is necessary? Select One

Is this transportation request temporary or permanent? ☐ Temporary *Expected End Date*_____ ☐ Permanent

V. Notification of Referral:

Date Individual Notified		Method of Notification	Select One

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VI. Referral Information:

Referral from MATP				
Reason for referral				
Entity Referred To	Date of Referral	Person Making Referral	Agency Making Referral	Phone Number
Select One				

Signature _____ **Date** _____

Referral from MCO				
Reason for referral				
Entity Referred To	Date of Referral	Person Making Referral	MCO Making Referral	Phone Number
Select One				

Signature _____ **Date** _____

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Instructions for Completing the Form:

I. Please indicate if the individual is being referred to the CAO, PH-MCO or CHC-MCO and using the drop-down box, select the specific entity.

II. Please complete all fields identifying the individual and if applicable, responsible party if individual is a minor or requires a representative on their behalf.

III. Please enter information about the individual's appointment, including the type of trip or service to be provided, if known. Also, please indicate whether the appointment is recurring. If so, please enter the day, time and any comments you wish to add about the appointment.

IV. Please indicate specific information about the trip.

V. The individual must be notified of the referral. Please indicate the date and method of notifying the individual.

NOTE: While the individual may be notified verbally by phone or in person, a written denial notice is still required.

VI. ***Please complete in detail the reason your entity cannot provide the requested transportation. Also, please be sure to indicate where the individual is being referred; include your name, telephone number and signature where indicated.***

NOTE: *Regardless of the entity referred to, a signature is needed from both the MATP agency and MCO before forwarding to the CAO.*

MATP Agencies: Please retain a copy for your records and forward a copy to your Program Monitor.