COUNTY OF ALLEGHENY

SARA INNAMORATO
COUNTY EXECUTIVE

Dear Applicant: _____ _____ CLIENT ID _____
Print first and last name (For MATP use only)

Welcome! Thank you for your interest in using the Medical Assistance Transportation Program (MATP).

The MATP application process is simple. You complete and sign the forms listed below and send them to us within 30 days of the "date of application." We review your application and determine if you are eligible to participate.

Please complete all blanks on these forms, unless noted "for MATP use only":

_____ **MATP Application/Eligibility –** helps us determine if you are eligible for service

_____ **Client Authorization for Release of Information –** gives MATP permission to receive / release information from medical facilities, physicians, dentists, hospitals, clinics, and ACCESS Transportation Inc. regarding your need for and / or receipt of MA-covered medical services.

_____ **This Welcome Letter –** your signature indicates that you kept the MATP Instruction & Information booklet and the MATP Holiday Schedule (enclosed).

Optional forms:

_____ **DHS voluntary survey** – completing this form is completely voluntary. What you answer will in no way affect your transportation service. Information you provide helps DHS plan better services.

Transportation services are available during the 30 days you have to return the completed/ signed required forms listed above. Services will be suspended if the required forms, with your signature, are not returned within 30 days of the "date of application" on the application form.

MATP is required to provide the least expensive, most appropriate transportation service that meets your need. Transportation options include:

- Reimbursement of mileage/parking/tolls for use of a private vehicle
- Port Authority bus/T/incline tickets
- Shared-ride paratransit / Ride-hailing service for those who we determine unable to use public transportation

We will discuss your transportation service with you as part of the application/ eligibility process.

You may return your completed, signed forms: by mail or hand-delivery: MATP, One Smithfield Street, 1st Floor, Pittsburgh, PA 15222-2221, **OR** by FAX: (412) 350-2729 **OR** by scan and email to: MATP@alleghenycounty.us .

Please call MATP at 1-888-547-6287 with any questions. Phones answer Monday through Friday, 8:00 a.m. to 4:30 p.m. If you must call at other times, leave a message and we will return your call on the next business day.

Regards,

James R. Farwell

MATP Administrator

☐ I have retained a copy of the MATP Instruction & Information Sheet and MATP Holiday Schedule:

X _____

Applicant signature **Date**

ERIN DALTON, DIRECTOR
DEPARTMENT OF HUMAN SERVICES
OFFICE OF BEHAVIORAL HEALTH
MEDICAL ASSISTANCE TRANSPORTATION PROGRAM (MATP)
HUMAN SERVICES BUILDING • ONE SMITHFIELD STREET • FIRST FLOOR • PITTSBURGH, PA 15222
PHONE (412) 350-4476 • FAX (412) 350-2729 • E-MAIL MATP@ALLEGHENYCOUNTY.US

Medical Assistance Transportation Program (MATP)
Adult (18 years and older) Application / Eligibility Form
1-888-547-6287

Reset Personal Info

Reset All

(PLEASE TYPE OR PRINT CLEARLY)

SECTION I – CLIENT IDENTIFYING INFORMATION

Prefix	Last name	First name	Middle name	Suffix	Client ID (for MATP use only)

Cell phone number (including area code)	Home phone number (including area code)	Social Security number	Date of birth (m-d-yyyy)

Pick-up Address

House number	Street name (include St., Ave., Rd.)	Apartment number

City / Township / Borough	County	State	ZIP
	Allegheny	PA	

Mailing Address (if different from pick-up address)

House number, street name, apartment number or P.O. Box	City	State	ZIP

Emergency Contact

Emergency contact name	Emergency contact phone number
Name of parent / guardian	Parent/guardian phone number

R-EC

For MATP use only

SECTION II – MEDICAL ASSISTANCE ELIGIBILITY VERIFICATION / REVERIFICATION

☐ Group I ☐ Group II (D-00, B-00, PD-00, PD-21, PD-22, PD-29, TD-00, TB-00)

Category of assistance		Program status code	
Plan name		Proof of age	

R II

Please read each item below. Then sign to say you agree to the items.

SECTION III – 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 PA Department of Human Services (formerly DPW) fair hearing.

This affirmation statement covers all attachments required for the determination of eligibility.

Signature of applicant	Signature of interviewer	Date of application m-d-yy
X		

Revised 4-12-18

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

Social Security Number or MA ID: _____

II. AUTHORIZATION. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("Authorized Party") to use or disclose the following:

Any medical-related information needed to verify my receipt of medical services for the purpose described below

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to:

Name:

Address:

Phone: (____)____ - _____ Fax: (____) ____ - _____

E-Mail: _____

IV. PURPOSE. The reason for this authorization is:

To verify attendance to the appointment for medical services for which you received transportation through the Medical Assistance Transportation Program.

V. TERMINATION. This authorization will terminate:

Upon sending a written revocation to the authorized party.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - **Being a Minor**. Patient is years old and considered a minor under state law.

☐ - **Being Incapacitated**. Patient is incapacitated due to: _____

☐ - **Other:** _____

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - **I consent** to have the above information released.

☐ - **I do not consent** to have the above information released.

Signature of Patient: _____ **Date:** _____

Print Name: _____

Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

AUTORIZACIÓN HIPAA PARA EL USO O DIVULGACIÓN DE INFORMACIÓN DE SALUD

Fecha: ____ de _____ de 20____

I. EL PACIENTE. Este formulario se utilizará cuando se requiera dicha autorización y se cumplan las Normas de Privacidad de la Ley de Portabilidad y Responsabilidad de los Seguros de Salud de 1996 (HIPAA, por sus siglas en inglés).

Nombre del Paciente: _____

Fecha de nacimiento: _____

Número de Seguro Social o ID de MA: _____

II. AUTORIZACIÓN. Autorizo a cualquier plan de salud, médico, profesional de la salud, hospital, clínica, laboratorio, farmacia, centro médico u otro proveedor de atención sanitaria que me haya proporcionado pago, tratamiento o servicios, o que los haya proporcionado en mi nombre ("Parte Autorizada") a utilizar o divulgar lo siguiente:

Cualquier información médica necesaria para verificar que he recibido los servicios médicos para los fines que se describen a continuación

En lo sucesivo, "Registros Médicos".

III. DIVULGACIÓN. La Parte Autorizada tiene mi autorización para divulgar mis Registros Médicos a:

Nombre: **[INGRESE EL NOMBRE DEL BENEFICIARIO DEL PROGRAMA MATP]**

Dirección: **[INGRESE LA INFORMACIÓN DE CONTACTO DEL ADMINISTRADOR DE MATP]**

Teléfono: (____)____ - _____ Fax: (____) ____ - _____

Correo electrónico: _____

IV. FINALIDAD. El motivo de esta autorización es:

Verificar la asistencia a la cita para servicios médicos para la que recibió transporte a través del Programa de Transporte de Asistencia Médica (MATP).

V. TERMINACIÓN. Esta autorización terminará:

Al enviar una revocación por escrito a la parte autorizada.

VI. RECONOCIMIENTO DE DERECHOS.

Entiendo que tengo derecho a revocar esta autorización, por escrito y en cualquier momento, excepto cuando ya se hayan hecho usos o divulgaciones sobre la base de mi permiso original. Es posible que no pueda revocar esta autorización si su finalidad era obtener un seguro.

Entiendo que los usos y divulgaciones ya realizados sobre la base de mi permiso original no se pueden revocar.

Entiendo que es posible que un destinatario de mis Registros Médicos o de mi información utilizada o divulgada con mi permiso puede volver a divulgarla y que tal información puede ya no estar protegida por las Normas de Privacidad de la HIPAA.

Entiendo que el tratamiento realizado por cualquier parte no puede estar condicionado a mi firma de esta autorización (a menos que el tratamiento se realice solo para crear Registros Médicos para un tercero o para participar en un estudio de investigación) y que puedo tener derecho a negarme a firmar esta autorización.

Recibiré una copia de esta autorización después de firmarla. Las copias de esta autorización tienen la misma validez que la original.

Firma del Paciente: _____ **Fecha:** _____

Nombre: _____

(SI EL PACIENTE NO PUEDE FIRMAR, UTILICE LA ZONA DE FIRMA DE ABAJO) El paciente no puede firmar debido a: (marque una opción)

☐ - **Es menor de edad**. El paciente tiene ___ años y es considerado menor de edad según la ley estatal.

☐ - **Está incapacitado**. El paciente está incapacitado debido a: _____

☐ - **Otro motivo:** _____

Firma del Representante: _____ **Fecha:** _____

Nombre: _____

Relación con el Paciente: ☐ Padre ☐ Cónyuge ☐ Tutor ☐ Otro: _____

CONSENTIMIENTO ADICIONAL PARA CIERTAS CONDICIONES

I. INFORMACIÓN SENSIBLE. Este historial médico puede contener información sobre abusos físicos o sexuales, alcoholismo, drogadicción, enfermedades de transmisión sexual, abortos o tratamientos de salud mental. Se debe dar un consentimiento por separado antes de divulgar esta información.

(marque una opción)

☐ - **Doy mi consentimiento** para que se divulgue la información anterior.

☐ - **No doy mi consentimiento** para que se divulgue la información anterior.

Firma del Paciente: _____ **Fecha:** _____

Nombre: _____

II. VIH/SIDA. Este historial médico puede contener información relativa a la prueba del VIH y/o al diagnóstico o tratamiento del SIDA. Se debe dar un consentimiento por separado para que se divulgue esta información.

(marque una opción)

☐ - **Doy mi consentimiento** para que se divulgue la información anterior.

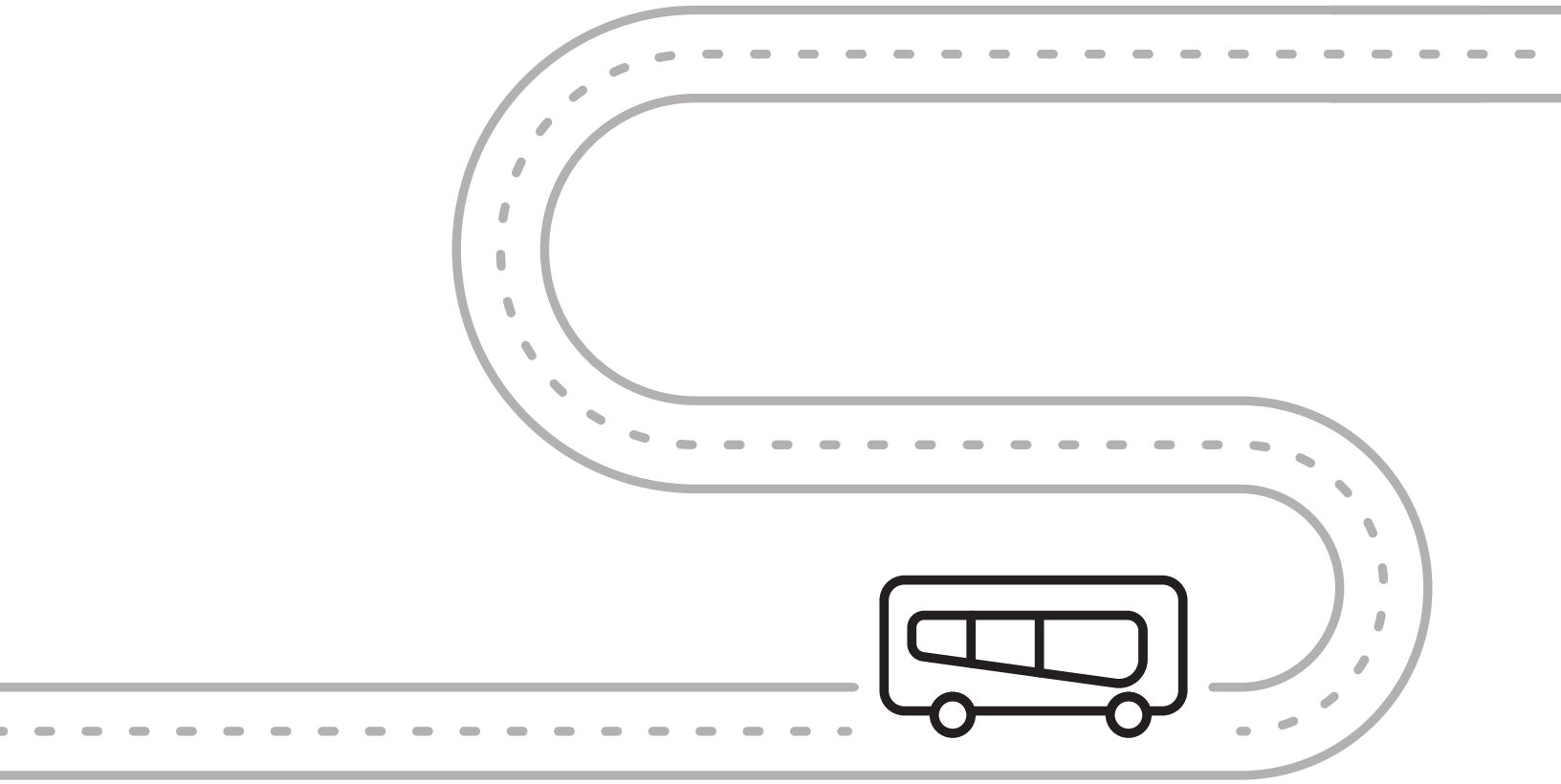
☐ - **No doy mi consentimiento** para que se divulgue la información anterior.

Firma del Paciente: _____ **Fecha:** _____

Nombre: _____

Medical Assistance Transportation Program (MATP)

Your Instructions and Information Booklet to help you make the most of MATP services



Important Numbers and Addresses

MATP
Allegheny County Department of Human Services
One Smithfield Street, First Floor
Pittsburgh, PA 15222
1-888-547-6287

Travelers Aid
343 Blvd of the Allies
Pittsburgh, PA 15222
412-281-5474

Director's Action Line (DAL)
One Smithfield Street, First Floor
Pittsburgh, PA 15222
1-800-862-6783

MATP ACCESS Carriers
Each carrier listed below provides service to specific areas of Allegheny County. You will be informed which carrier will provide your transportation if you are approved for ACCESS shared-ride transportation. If you qualify, circle your ACCESS provider for easy reference.

AirStar
412-381-7230

NAMS
412-781-6774

PRN
1-888-634-8773

S&S
412-829-7627

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Introduction

This booklet contains all the information you need to successfully use MATP services. Please keep it handy and refer to it when you have questions. If you still have questions about MATP, please call us at 1-888-547-MATP (6287). *We will be happy to help.*

How to Apply to Use MATP

Individuals of all ages may qualify for the Medical Assistance Transportation Program (MATP) if they

- are a resident of Allegheny County and
- have a valid Pennsylvania Medical Assistance (MA/Medicaid) card

You just need to complete the application process and have your eligibility verified by MATP to use the service.

The application process for adults, 18 years of age and older, is provided on the Welcome Letter in the "MATP Application Packet for Adults."

The application process for children, under 18 years of age, is provided on the Welcome Letter in the "MATP Application Packet for Minors."

Both packets, and an on-line application, are available on the DHS MATP webpage: www.alleghenycounty.us/dhs/matp

If someone helped you complete the forms and they are sent to you by mail, you must sign and return your required forms within 30 days of the "date of application," as provided in the bottom, right-hand corner of the application, for your MATP transportation services to continue.

NOTE: Transportation is available during the 30 days processing time but will be suspended if the required documents with your signature are not received within those 30 days.

The application process is complete when the MATP office receives your completed and signed MATP documents and lets you know you qualify.

The MATP representative will discuss the specifics of your available services when she or he calls you.

General Information about MATP

MATP can provide

- Free public transportation (bus, subway and incline) ahead-of-time tickets
- Reimbursement for your use of public transportation or a private car
- Free door-to-door service, when medically necessary, via shared-ride or ride-hailing service

MATP is required by law to provide the least costly, most appropriate transportation service available that fits a rider's needs.

If you qualify, MATP can take you (and your escort, if necessary) to and from these MA-billable appointments for free.

- Non-emergency medical trips related to your physical health
  - Doctor appointments
  - Dental appointments
  - Pharmacy visits to get prescription medication (not available with ride-hailing)
- Non-emergency medical trips related to your mental health counseling
- Non-emergency medical trips related to counseling and treatment for drug and alcohol dependency
- Urgent-care trips (next day or same day) if determined to be eligible after a case-specific review

MATP does not provide transportation for these non-MA-billable reasons

- Emergency ambulance service
- Trips of distances less than one-quarter of a mile unless you are unable to walk the distance
- Transportation to or from
  - Veterans Administration (VA) medical centers
  - Mental health social rehabilitation programs
  - Hospital visits
  - Day care programs
  - Sheltered workshops
  - WIC programs
  - Nutrition programs

Rules for riders on all MATP vehicles

Young riders

- Qualified children under 18 years of age may ride MATP if their parent or legal guardian signs and returns all required documents in the MATP Application Packet for Minors.
- Children under four years of age must ride in an approved car seat provided by the parent or legal guardian. The parent or legal guardian must ride with the child.
- Children between four and eight years of age must ride in an approved booster seat provided by the parent or legal guardian. The parent or legal guardian must ride with the child.
- Children 13 to 17 years of age must have a signed "Permission for a Minor to Ride MATP Alone" form on file whether or not the child is permitted to ride alone.

Escorts

- MATP does not provide escorts. It is your responsibility to arrange for an escort, if needed.
- Escorts must be 18 years of age or older.
- Reasons to have an escort:
  - You are unable to safely ride alone
  - The effect of your pending medical treatment will result in you being unable to safely ride alone
  - You need help to speak with, understand or remember what your medical professional said
- Travel arrangements for escorts and registered service animals must be made when you schedule your trip.
- All escorts ride for free.

Changes to your personal information

You must let MATP know right away if any of your personal information changes from what was reported on your MATP application. Call 1-888-547-MATP (6287) if:

- You move from the address on your application form
- Your telephone number changes
- Your Medical Assistance (Medicaid) eligibility changes or is terminated

Reasons your use of MATP service may be stopped

The reasons that your MATP services may be temporarily or permanently stopped include but are not limited to:

- If applying by mail, you do not sign and return the required forms from the MATP Application Packet within 30 days of the date of application.

- You move outside Allegheny County
- You are longer eligible for Medical Assistance
- You are abusive or uncooperative toward MATP staff or to the driver or other passengers when using MATP transportation services
- You use the service for reasons that are not permitted or acceptable

If your service is denied, reduced or ended, you will be sent written notice about your right to request a fair hearing from the PA Department of Human Services. If you have questions about this, please call the MATP administrator at 1-888-547-MATP (6287) or Neighborhood Legal Services at 412-255-6700.

MATP is closed on weekends and county-observed holidays

Even though the MATP office is closed on weekends and the holidays listed below, you can still use MATP services 365 days a year. You just need to take these closed days into account when scheduling your service.

- New Year's Day - Jan. 1
- Martin Luther King Jr. Day - third Monday of January
- President's Day - third Monday of February
- PA Primary Election Day - varies
- Memorial Day - last Monday of May
- Juneteenth - June 19
- Independence Day - July 4
- Labor Day - first Monday of September
- Columbus Day/Indigenous People's Day - second Monday of October
- Veterans' Day - November 11
- Thanksgiving - fourth Thursday of November
- Christmas Day - December 25

If You Have a Question or Complaint

Contact MATP

- By Phone Weekdays, 8:00 am to 4:30 pm
  1-888-547-MATP (6287)
- Walk-ins Weekdays, 8:30 am to 3:30 pm
  The Human Services Building
  One Smithfield Street, First Floor
  Pittsburgh, PA 15222
- Email MATP@alleghenycounty.us

Contact the Director's Action Line (DAL)

- By Phone Weekdays, 8:00 am to 5:00 pm
  1-800-862-6783
- Walk-ins Weekdays, 8:30 am to 4:30 pm
  The Human Services Building
  One Smithfield Street, First Floor
  Pittsburgh, PA 15222
- Email DAL@alleghenycounty.us
- Text "Action" to 412-324-3388

Using Public Transportation for Your MATP Trip

Public transportation ahead-of-time tickets

For first-time riders or people whose facility is not in the Travelers Aid network

1. At least one week before your scheduled medical appointment, call Travelers Aid at 412-281-5474.

   NOTE:

   - There is no guarantee that you will get your tickets on time if your request is placed less than one week ahead of time.
   - If you don't get your tickets in time, and you pay out of pocket for your public transportation tickets, you have 10 days from date-of-service to submit acceptable documentation of your visit to: Travelers Aid,
     343 Blvd of the Allies, Pittsburgh, PA 15222:
     - Acceptable documentation means the staff at the facility must write on facility/physician letterhead, prescription pad or after-visit summary that you were there for an appointment.
     - Reimbursements cannot be made if documentation is received more than 10 days after the date-of-service.
     - Reimbursement will be paid in bus tickets.

2. Travelers Aid will send the tickets through the mail to your home address in time for your appointment.

3. The envelope will also have a Verification of Billable Services form to be signed by a facility staff member after your appointment is complete.

4. You must send the Verification of Billable Services form, signed by the facility staff, back to: Travelers Aid, 343 Blvd of the Allies, Pittsburgh, PA 15222, within 10 days of your appointment to get tickets for future appointments. If you break this rule three times, you will no longer be able to get tickets ahead of time. You will need to ask to be paid back.

For persons whose facility is in the Travelers Aid network

Because the medical facility that you visit is in the Travelers Aid network, staff there will provide you with that day's return ticket and a bus ticket to get to your next visit.

You are still required to send the signed Verification of Billable Services form to Travelers Aid, 343 Blvd of the Allies, Pittsburgh, PA 15222, within 10 days of your appointment.

Public transportation: Requesting your after-your-appointment payback

Only documented transportation expenses to MA-eligible medical appointments will be reimbursed.

Within 15 days of your appointment, send to:
MATP Office, One Smithfield Street, First Floor, Pittsburgh, PA 15222:

1. Proof of visit

- To be reimbursed for travel to/from a medical office visit: Proof of your completed medical visit on the office's official letterhead, prescription pad or after-visit summary that includes the address of the appointment location

  OR

- To be reimbursed for travel to/from a pharmacy prescription pick-up visit: The prescription receipt with your name and the cash register receipt that has the day you picked up your prescription

2. Proof of costs for your travel

- You don't need to send anything for proof of cost, your home address and the address of your medical appointment or pharmacy will determine actual travel cost based on published public transportation fares

You will receive a reimbursement check after your information is verified.

Using a Private Vehicle for Your MATP Trip

If you have access to a private vehicle, you may use it for any MA-eligible appointments and receive mileage reimbursement as well as parking and tolls when receipts are provided.

Requesting your after-your-appointment payback

Within 15 days of your appointment, send to:
MATP Office, One Smithfield Street, First Floor,
Pittsburgh, PA 15222:

1. Proof of visit

- To be reimbursed for travel to/from a medical office visit: Proof of your completed medical visit on the office's official letterhead, prescription pad or after-visit summary that includes the address of the appointment location

  OR

- To be reimbursed for travel to/from a pharmacy prescription pick-up visit: The prescription receipt with your name and the cash register receipt that has the day you picked up your prescription

2. Proof of costs for your travel

- Send receipts (original and unchanged) for parking and tolls with your trip verification
- Your home address and the address of your medical appointment will determine actual travel cost based on a per-mile rate

You will receive a reimbursement check after your information is verified.

Using ACCESS (Shared-ride Transportation) for Your MATP Trip

Additional information for ACCESS riders

- ACCESS vehicles operate seven days a week,
  6:00 am to 10:00 pm, year-round, including holidays.
- ACCESS may automatically cancel your trip when Pittsburgh Public Schools are closed due to bad weather unless you receive life-sustaining medical treatment. Scheduled pick-up times may be delayed or travel restricted for safety concerns.
- You need to make sure the pathway between
  your door and the ACCESS vehicle is clear of all obstructions. The ACCESS driver will not shovel snow or chip ice.
- ACCESS drivers may help you up or down no more than four steps.

- Scheduling and cancellation of ACCESS trips must be done according to the process below.
- Only clients and escorts authorized by MATP are permitted on ACCESS vehicles.
- Please be ready at least 15 minutes ahead of your scheduled pick-up time.
- ACCESS vehicles are permitted to be between 10 minutes early and 20 minutes late for their scheduled pick-up time.
- ACCESS vehicles will only wait five minutes at a pick-up site.
- No smoking is permitted on ACCESS vehicles.
- The vehicle that arrives for you may be a van, a wheelchair-lift-equipped vehicle or a sedan. No matter what form it takes, all ACCESS vehicles are marked with the carrier's logo.
- A list of ACCESS carriers and their phone numbers is provided on page 2.

To schedule an ACCESS MATP round-trip

Remember, the MATP office is closed on weekends and all county-observed holidays. Please see the list of county-observed holidays on page 7.

NOTE: If you have an active MATP and ACCESS account, you may call your ACCESS service provider, on the day before your trip before 3:00 pm, to schedule it. Contact information is listed on page 2.

- Otherwise, contact MATP up to two weeks before but at least two weekdays before your appointment, as shown in the chart below.
  - by phone toll-free 1-888-547-MATP (6287); 8:00 am to 4:00 pm
  - by walk-in MATP Office, Human Services Building, First Floor, One Smithfield Street, Pittsburgh, PA 15222; 8:30 am to 4:00 pm

Day of your appointment	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Deadline to call MATP to schedule a ride.	By 4:00 pm on the previous Thursday	By 4:00 pm on the previous Friday	By 4:00 pm on the previous Monday	By 4:00 pm on the previous Tuesday	By 4:00 pm on the previous Wednesday	By 4:00 pm on the previous Thursday	By 4:00 pm on the previous Thursday

- Next-day trips are considered on a case-by-case basis. If calling for a next-day trip, you must contact MATP before 3:00 pm the previous weekday.
- Be ready to tell the MATP interviewer:
  - The address, including street name, number and zip code of your medical appointment
  - The purpose of your medical appointment
  - The name of the physician you will be seeing or facility you will be going to and their office phone number
  - The time of your appointment

To request your "will-call" return MATP trip on ACCESS

- Call your assigned ACCESS carrier for your return trip home unless you are told otherwise. Phone numbers for all the ACCESS carriers are listed on page 2.
  - If your appointment is scheduled to begin before 2:30 pm, you can use a will-call return trip. ALL calls for will-call return trips must be made to the carrier before 5:00 pm.
  - If your appointment is scheduled after 2:30 pm, you must tell the carrier a return time in advance.
- Drivers may arrive within five minutes or up to 45 minutes after your call for pick-up.
- Call the carrier if you have waited 45 minutes and your driver has not arrived.

To cancel an ACCESS MATP trip

Call your carrier directly at least one hour before your scheduled pick-up time to cancel your trip. Phone numbers for all the ACCESS carriers are listed on page 2.

What happens if you do not cancel or use your scheduled ACCESS ride?

- Your record will be marked with a "no-show" if you call to cancel less than one hour ahead or if you do not arrive at the ACCESS vehicle within five minutes of it arriving at your location.
- If your record shows that you were a no-show for two consecutive pick-ups, your service may be discontinued. MATP will attempt to contact you after the second no-show to give you a chance to explain. If you cannot be reached the assumption will be that you do not need the service and your next trip will be canceled by MATP.

Using the MATP Ride-hailing Service

General information about MATP ride-hailing

MATP determines eligibility for all transportation options, including MATP ride-hailing, based on the most appropriate, cost-effective mode of transportation. Clients cannot sign themselves up for ride-hailing. Those interested in being signed up should call MATP at 1-888-547-MATP (6287).

NOTE: Only those who are already registered with MATP AND determined to be eligible AND referred to Travelers Aid by MATP AND approved by Travelers Aid may utilize this service.

Additional rules for MATP ride-hailing

- MATP ride-hailing rides use Uber, Lyft, and zTrip vehicles.
- Pick-up times for "to" rides using MATP ride-hailing services are available Monday through Friday starting at 8:45 am.
- Arrangements for after-appointment pick-ups must be made by 4:00 pm.
- Since rides are scheduled by Travelers Aid and Travelers Aid is closed on weekends and holidays, (see below) any travel needed during these blackout periods must be arranged using a different MATP service.
- Travelers Aid will call to alert you of the driver's arrival time, the make and model of the car, the company of the car (Uber, Lyft or zTrip) and the name of the driver.
- The driver will already know your name and destination when s/he arrives.
- You must be ready when the driver arrives for pick-up to or from your appointment.
- No assistance is provided to the rider by the Uber, Lyft or zTrip driver.
- MATP ride-hailing does not provide transportation to pharmacies for prescription pick-up.

Travelers Aid is closed on weekends and some holidays

Travelers Aid is closed on weekends and on the following holidays, so you cannot use MATP ride-hailing on weekends or the holidays listed below.

- New Year's Day - Jan. 1
- President's Day - third Monday of February
- Good Friday - Friday before Easter
- Memorial Day - last Monday of May
- Juneteenth - June 19
- Independence Day - July 4
- Labor Day - first Monday of September
- Columbus Day/Indigenous People's Day - second Monday of October
- Veterans' Day - November 11
- Thanksgiving Day - fourth Thursday of November
- Day after Thanksgiving - fourth Friday of November
- Christmas Day - December 25

Scheduling an MATP ride-hailing “to” trip

- If you have been referred by MATP to Travelers Aid to utilize ride-hailing service and have registered for this service, you may contact Travelers Aid at 412-436-9621 so they can schedule your ride.
- You must call Travelers Aid to schedule your trip between 8:30 am and 3:00 pm, Monday through Friday up to one week ahead but at least the day before your appointment.
- You must schedule Monday pick-ups no later than 3:00 pm the previous Friday.

Requesting an MATP ride-hailing “return” trip

All calls to request a return trip using ride-hailing service must be made to Travelers Aid at 412-436-9621 by 4:00 pm.

Making your own ride-hailing arrangements

Customers who meet certain criteria may be able to book trips on their own using a smartphone. Contact Travelers Aid at 412-436-9621 Monday through Friday between 8:30 am to 3:00 pm for more details.

Allegheny County
Department of Human Services
One Smithfield Street
Pittsburgh, Pennsylvania 15222
www.connect.alleghenycounty.us
www.alleghenycounty.us/dhs

Current as of August 2024

RESET

Allegheny County Department of Human Services
Voluntary Survey

Please check the description that most closely identifies your current marital status:

- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Never Married
- ☐ Married

Please check the description that most closely identifies the educational level you last completed:

- ☐ Pre-school (0-3 years old)
- ☐ Pre-school (4 years old - Kindergarten)
- ☐ Kindergarten – 4th Grade
- ☐ 5th – 7th Grade
- ☐ Special School 1-3 years
- ☐ Special School 4-6 years
- ☐ 1-3 years of High School/ Vocational/ Technical School
- ☐ 4 years of High School/Vocational/ Technical School
- ☐ Alternative School
- ☐ GED
- ☐ 1-3 Years of College/Business/ Technical School
- ☐ 4 Years of College/Business/ Technical School
- ☐ Graduate or Professional School 1 or more years
- ☐ None
- ☐ Unknown

Please check the description that most closely identifies your current state of employment:

- ☐ Affirm. Industry employ (20 hours or less per week)
- ☐ Affirm. Industry employ (21 hours or more per week)
- ☐ After school/summer employment
- ☐ Attending college (6 or less credits)
- ☐ Attending vocational school/training
- ☐ Basic academic preparation
- ☐ Disabled
- ☐ Full time employment
- ☐ Full time Special Day Treatment
- ☐ Full time in regular class
- ☐ Full time student
- ☐ Home bound Instruction
- ☐ Homemaker
- ☐ Leave of Absence
- ☐ Part time employment and in school
- ☐ Part time
- ☐ Prevocational training
- ☐ Retired
- ☐ Seeking employment
- ☐ Sheltered employment
- ☐ Sheltered Workshop
- ☐ Supported employment (20 hours or less per week)
- ☐ Supported/transitional employment
- ☐ Transitional employment (20 hours or less per week)
- ☐ Transitional employment (21 or more hours per week)
- ☐ Unemployed
- ☐ Work Study

Please check the description that most closely identifies your ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Please check the description that most closely identifies your current living arrangement:

- ☐ Correctional facility
- ☐ CYF residential system
- ☐ DA residential system
- ☐ Hospital
- ☐ ID residential system
- ☐ MH residential system
- ☐ Nursing home
- ☐ Personal care/other privately purchased housing
- ☐ State system
- ☐ Homeless or Shelter/Mission
- ☐ Independent (alone or with family/friends)
- ☐ Independent with supports
- ☐ Independent with no supports

Please check the description that most closely identifies your race:

- ☐ Asian
- ☐ Black
- ☐ Native American/Alaskan Native
- ☐ Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown