

FULTON COUNTY PARTNERSHIP, INC.

MATP APPLICATION

PART A—TO BE COMPLETED BY APPLICANT OR REPRESENTATIVE Please type or print neatly

1	APPLICANT NAME—Last, First M.I.				DATE OF APPLICATION	
	ADDRESS—Street			APT. #		COUNTY OF RESIDENCE
	CITY		STATE	ZIP	PHONE (Area Code First)	
2	SOCIAL SECURITY NUMBER		DATE OF BIRTH (MM/DD/YYYY)		AGE	SEX (Circle one) M F
	MA NUMBER			ISSUE NUMBER	DATE OF ISSUE (MM/DD/YYYY)	

HOUSEHOLD MEMBERS: Please list the members of your household. Include spouse and any minor children attach adt'l. sheets if needed							
1	First Name		Last Name		Social Security Number		Relationship
	Date of Birth	Age	Sex (M or F)	Receive MA (Yes/No)	If yes, MA #		Issue #
2	First Name		Last Name		Social Security Number		Relationship
	Date of Birth	Age	Sex (M or F)	Receive MA (Yes/No)	If yes, MA #		Issue #
3	First Name		Last Name		Social Security Number		Relationship
	Date of Birth	Age	Sex (M or F)	Receive MA (Yes/No)	If yes, MA #		Issue #

CERTIFICATION / RELEASE OF INFORMATION						
4	<p>1. I authorize and request the disclosure to the Fulton County Partnership, Inc. or its authorized agent to verify any information that may be desired concerning residence, MA Number or any other information I have given concerning this application for the Medical Assistance Transportation Program (MATP). I understand that the information obtained will be used only for purposes directly related to my eligibility for the Medical Assistance Transportation Program.</p> <p>2. I authorize release of information to _____ involved in providing any services for which I may be eligible.</p> <p>3. I understand my social security number may be used to check the information on this application and in computer matches with other agencies.</p> <p>4. I understand that I may follow the grievance procedure if I do not agree with the decision made on this application.</p> <p>I certify that the information provided on this application is true and correct under penalty of perjury.</p>					
	SIGNATURE _____				DATE _____	

PART B—TO BE COMPLETED BY FULTON COUNTY PARTNERSHIP, INC.

Has the Eligibility form been completed?	Eligibility determined (Date)	Eligibility Determined by:	Staff Signature	Date
Eligibility: <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible		Missing items if any:		

PART C—COMMENTS (INCLUDE DIRECTIONS TO CLIENTS HOUSE OR PICK UP LOCATION)