

DAUPHIN COUNTY MH/ID PROGRAM MATP POLICY AND PROCEDURE

Agency	<input checked="" type="checkbox"/> CCB	Policy No. <u>07-07</u>
	<input checked="" type="checkbox"/> County	Effective Date <u>July 1, 2007</u>
	<input checked="" type="checkbox"/> CAT	Revision Date <u>February 9, 2017</u>
	<input checked="" type="checkbox"/> Other	Approved <i>David E. Eckenrode</i>

Title: MATP Consumer No Show

Policy: The Dauphin County MH/ID MATP shall ensure that the MATP Eligibility Provider has an established No Show policy and procedure in compliance with the MATP Standards and Requirements.

Definitions:

MATP Standards and Requirements: The document published by the Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs, that governs the operation and funding of the Medical Assistance Transportation Program.

MATP Eligibility Provider: The agency contracted by the Dauphin County MH/ID Program to determine MATP consumer eligibility and transportation mode to be used for Medical Assistance Transportation services.

MATP Providers: All providers/agencies that are under contract with the Dauphin County MH/ID Program to provide Medical Assistance Transportation services.

MATP Provider Sub-Contractor: All providers or agencies sub-contracted for MATP services by any agency that has a contract with the County MH/ID Program for the MATP.

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.

No Show: An MATP consumer who schedules MATP transportation, but who is not available to be transported at the arranged time and place to board an MATP vehicle. A consumer who is attending a scheduled appointment is not considered a "no show" unless the consumer abandons the return trip without notice.

MATP Written Notice Form: A DHS form that the MATP Consumer Eligibility Provider provides to the MATP Consumer at the time their request for services is denied, terminated, or reduced, or the mode is changed as a result of this policy.

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Procedure:

1. The MATP Eligibility Provider must submit their Consumer No Show Policy to Dauphin County MH/ID MATP for approval.
2. Upon approval, the Dauphin County MH/ID MATP will submit this policy to the Office of Medical Assistance Programs as part of the MATP Service Plan.
3. All MATP Providers and MATP Sub-Contractors shall report consumer no shows, patterns of, or excessive consumer no shows to the MATP Eligibility Provider.
4. MATP Providers shall attempt to mitigate the circumstances that may be contributing to consumer no shows.
5. As a result of confirmed consumer No Shows, the following actions may be taken.
 - A. A notification letter may be sent to the consumer that describes potential consequences for no shows such as:
 - B. Require the consumer to schedule transportation services on a per ride basis rather than by standing orders.
 - C. Re-examine the mode of transportation such as using fixed route versus shared ride
 - D. If appropriate, the eligibility agency may contact recipient's dialysis provider to improve trip scheduling coordination and notification about medical issues that impact consumer no shows.
6. The Eligibility provider will not take any action described above without prior written notice.
7. The Dauphin County MH/ID MATP Staff will assure that the MATP Eligibility Provider is utilizing the approved Consumer No Show Policy through a review of the Consumer No Show Procedures during monitoring visits.

**MEDICAL ASSISTANCE TRANSPORTATION PROGRAM
WRITTEN NOTICE FORM**

**DATE THIS NOTICE WAS
MAILED OR HAND
DELIVERED TO YOU:**

NAME: _____
ADDRESS: _____

SECTION I - NOTICE

THIS IS TO NOTIFY YOU YOUR REQUEST

HAS BEEN:

- For MATP Services
- For Transportation Services on:

- For Mileage Reimbursement on:

- Denied
- Terminated Effective: _____
(date)
- Reduced or Service Type Changed:

For the Following Reason:

The regulatory or other basis for this decision is:

SECTION II – APPEAL RIGHTS AND RESPONSIBILITIES

You have the right to appeal this decision and request a Fair Hearing through the Department's Bureau of Hearings and Appeals if you disagree with the decision. The purpose of a Fair Hearing is to determine if the decision was based on a proper application of the law to your particular circumstances. Therefore, you do not have the right to appeal a decision that is based on changes in federal or state law or regulations which now exclude you from eligibility for service or reduce the amount of service you may receive. (See Section IV)

To appeal this decision and request a Fair Hearing you must complete the reverse side of this form. Then, you must mail or hand-deliver this form plus one copy to the _____ (agency)
located at _____ (address).

The forms must be postmarked or hand-delivered by _____, which is thirty (30) calendar days following the date this notice is mailed or hand-delivered to you.

If you are currently receiving service and your form is postmarked or hand-delivered on or before _____, your service will be continued pending the outcome of your appeal.
If your form is postmarked or hand-delivered after this date, service will be discontinued.

You may contact _____ at _____ if you need assistance filling in your request for a Fair Hearing, or if you do not understand this decision or would like to meet with a representative of our agency.

SECTION III – AGENCY INFORMATION

AGENCY NAME: _____

AGENCY ADDRESS (Street, City, State, Zip Code): _____

Agency Representative Signature/Date

Telephone Number

SECTION IV – FILE AN APPEAL

RIGHT TO AN APPEAL AND TO A FAIR HEARING

You have the right to file an appeal within the time limits specified on the other side of this form and request a Fair Hearing from the Department of Public Welfare.

In order to request a Fair Hearing, you must do the following:

- (1) Give your reason(s) for the appeal in the space provided below.
- (2) Give your telephone number; including area code in the space provided.
- (3) Give your exact address.
- (4) Mail or take this form to the address of the agency specified in Section III.

You have the right to represent yourself or to have anyone represent you. You can ask the service provider agency to direct you to the local legal services offices if you want information about obtaining a lawyer to represent you at a hearing.

Before the scheduled hearing takes place, your or your representative has the right to examine all information which the agency will introduce as evidence at the hearing.

If you and your representative would like to meet with the service provider agency staff to discuss the matter informally or to present information which might change the proposed action, please call the agency representative specified in Section III.

If you need an interpreter at the hearing because you do not speak English or because you have limited understanding of English, the Department will arrange for an official interpreter at no cost to you. You may bring a friend or relative to assist you at the hearing, but the interpreter provided by the Department will be the official interpreter.

During the hearing an Administrative Law Judge will ask you to explain why you appealed and why you disagree with the decision by the service provider agency. All facts will be studied and a ruling will be made as to whether the decision of the service provider agency is in accordance with the Department of Public Welfare's regulations.

The Bureau of Hearings and Appeals will hold a hearing for you either over the telephone or face-to-face. You may choose which type you want. If you do not have a telephone in your home and cannot get to one (for example, friend or relative's telephone) you may go to the telephone hearing at the service provider agency against which you filed the appeal.

Please indicate which type of hearing you want:

- I want a telephone hearing.
- I want a face-to-face hearing.

I WANT A HEARING BECAUSE:

(Please state a reason(s) for your appeal): _____

YOUR MAILING ADDRESS AND TELEPHONE NUMBER ►

_____	()
_____	_____

If someone will be representing you at the Hearing, please list their name, address and telephone number. ►

_____	()
_____	_____

I understand I will receive notification of the Hearing arrangements

_____	_____
Signature of Consumer	Date

_____	_____
Signature of Person Acting on Behalf of Consumer	Date

Mail or Hand-Deliver to the Agency specified in Section III of this form.