



**West Virginia Department of Health and Human Resources  
Perinatal Programs' Maternity Services Project  
Access to Rural Transportation (ART) FORM  
Verification of Attendance/Application**

**SECTION I: IDENTIFYING INFORMATION**

Case Number \_\_\_\_\_

Case Name: \_\_\_\_\_

ART Office \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Patient's Name(s) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The person listed above has indicated to Access Rural Transportation Service (ART) that she or a member of her family has a continuing need for medical services and that she needs assistance in securing funds for transportation to a medical or other facility.

**SECTION II: VERIFICATION OF ATTENDANCE**

In order for ART to provide these transportation funds, it is necessary to certify the patient's attendance at your facility through completion of this form.

Name of Facility: \_\_\_\_\_

Date Patient Attended: \_\_\_\_\_

Signature of Facility Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION III: PATIENT'S RESPONSIBILITIES:**

To the Patient:

Who will provide transportation? (Circle one) You, Family, Friend, Volunteer, Foster Parent, AFC Provider, other.

Please request the Facility Representative to complete Section II above.

After the form is completed it must be returned as instructed below to:

\_\_\_\_\_ (Art Office)

\_\_\_\_\_ (Street Address)

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)

**Please return this completed form to the ART Office at the above address no later than 60 days from the date of the trip(s) for which you are requesting benefits verified in Section II above. Failure to return this form within the deadline date will result in a denial of benefits.**

Payment may be made only when preauthorization or approval is received from the office of ART Services and when Section IV on the reverse side of this form is completed by the provider.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized by \_\_\_\_\_ Date \_\_\_\_\_

*(See reverse side for Section IV, Provider Information)*

SECTION IV: IDENTIFYING INFORMATION

Provider's Name: \_\_\_\_\_

Provider Number \_\_\_\_\_

Address: \_\_\_\_\_

Date of Travel \_\_\_\_\_

Telephone No: \_\_\_\_\_

Destination of Trip \_\_\_\_\_

Mileage & Travel

Trip Route

Odometer Reading

Ending \_\_\_\_\_

Beginning \_\_\_\_\_

Total Mileage \_\_\_\_\_

Other expenses:  
(Attach Verification if required)

Amount \$ \_\_\_\_\_

Reason: \_\_\_\_\_ Total Payment Due: \$ \_\_\_\_\_

I certify that the information provided above is true and correct to the best of my knowledge and as a transportation provider for the Department of Health and Human Resources, I agree to carry on my vehicle liability insurance required by state law of West Virginia and that I have special seats in my vehicle for the safe containment of children as required by state law.

Signature \_\_\_\_\_ Date \_\_\_\_\_