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:_____
Social Security Number:_____
Address:_____

ART Office _____
Patient's Name(s)

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

Odometer Reading

Ending _____

Beginning _____

Total Mileage _____

Other expenses:
(Attach Verification if required)

Amount $_____

Trip Route

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 _____