Dear Recipient:

Thank you for your interest in using an Individual Transportation Participant (ITP). An ITP can be reimbursed for driving you to your health care appointments. The enclosed enrollment packet includes the documents the ITP must submit to MTM. Refer to the ITP Enrollment Checklist for a list of required items. These items must be processed and approved by the state of Texas. The ITP cannot take any trips until the items are approved.

An ITP could be either of the following:

- ITP (Self): A Medicaid client who transports him/herself to a health care appointment using a personal vehicle OR an individual who transports a family member who is a Medicaid client using a personal vehicle
- ITP (Other): An individual who transports non-related Medicaid clients to a health care appointment using a personal vehicle; these individuals must undergo a Criminal History check

The ITP must show on the ITP Information Page if they are applying as “Self” or “Other.” **The required information must only be provided for the person who will be driving.**

Completed documents and other required items should be submitted via mail or fax to:

MTM, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax Number: 844-549-8349
Web Mail: txitp@mtm-inc.net

Please remember to call MTM at 1-855-687-4786 before your ITP drives you to any appointments. An ITP Service Record is included in the enrollment packet. Your ITP should use this form to request reimbursement. Make copies of this form for future trips. The form can also be found at www.mtm-inc.net/texas.

If you have any questions about this process, please call 1-855-687-4786.

Sincerely,

Joel Smith
Program Director

ITP Service Record (Claim Form)

*Client Name:	Client Telephone:	*Client Medicaid:
	( )	
*ITP Name:	ITP Telephone:	*ITP MTI Number:
	( )	

Trip #1			
From:	To:	Miles:	Amount:
From:	To:	Miles:	Amount:
*Authorization Number:	*Appointment Date/Time:	Total Miles:	Total Amount:
Health Care Provider NPI:	Health Care Provider Telephone:	*Health Care Provider Name:	
	( )		
I certify that this patient was seen for a Medicaid/CSHCN covered health care service.	*Signature & Title of Health Care Provider:	*Date Signed:	

Trip #2			
From:	To:	Miles:	Amount:
From:	To:	Miles:	Amount:
*Authorization Number:	*Appointment Date/Time:	* Miles:	Total Amount:
Health Care Provider NPI:	Health Care Provider Telephone:	*Health Care Provider Name:	
	( )		
I certify that this patient was seen for a Medicaid/CSHCN covered health care service.	*Signature & Title of Health Care Provider:	*Date Signed:	

ITP Drivers: To process your mileage claim, please ensure that fields with an asterisks (*) are filled in. Please note that the allowable mileage that may be claimed for reimbursement is calculated by the managed transportation organization using an online mileage application.

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

____ ____________________

Signature of Individual Transportation Participant (ITP) **Date**

Please retain a copy for your records. All forms must be mailed or faxed to:
MTM, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax Number: 888-407-0936/**Web Mail:** txgmr@mtm-inc.net

Revised October 2020

Individual Transportation Participant (ITP) Enrollment Checklist

Use this checklist to make sure all the items needed to sign up to be an ITP are completed and submitted.

No trips will be authorized until all documents have been approved.

For help filling out these forms, call MTM, Inc.'s Contact Center at 1-855-687-4786

- ☐ A copy of your completed ITP Information Page
  (Please fill out everything, and mark N/A if a question does not apply)
- ☐ A copy of your completed Client/ITP Information Page
- ☐ A copy of your completed Terms and Conditions of Participation Page
- ☐ A copy of your current and valid Driver's License
- ☐ A copy of your current and valid auto insurance card
- ☐ A copy of your Social Security card
- ☐ A copy of your current vehicle registration and inspection renewal

Important: The name listed on your driver's license and Social Security card must be the same.

MTM will send you a debit card from US Bank once you have submitted your first, properly completed, claim form. Funds will then continue to be loaded onto this debit card for each completed, approved trip.

OR

Get your money faster with Electronic Funds Transfer (EFT)
For faster payment with direct deposit to your bank account, fill out the enclosed EFT Notification form located on page 5 of this application.

All forms must be mailed or faxed to MTM, Inc.
MTM, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367
Fax Number: 844-549-8349
Web Mail: txitp@mtm-inc.net

Note: *Please retain a copy for your records.*

ITP Information Page

The purpose of the form is to obtain data to sign up to be an ITP. You must fill out this entire form and sign it. Please use blue or black ink. Original signature only; copies or stamped signature will not be accepted. Important: the name on your driver's license and social security card must be the same.

ITP Status (Self/Other):	**Telephone Number:**	
	( )	
Information Must Match Driver's License		
Last Name:	**First Name:**	**Middle Initial:**
Please Attach a Copy of Your Social Security Card		
Social Security Number:	**Date of Birth:**	
Please Attach a Copy of Your Driver's License		
Driver's License Number:	**License Issue Date (MM/DD/YYYY):**	**License Exp. Date (MM/DD/YYY):**
Physical Address *(this is where you live. You must give a street address. PO boxes will not be accepted.)*		
Number/Street:	**City, State:**	**Zip Code:**
Mailing Address		
Number/Street:	**City, State:**	**Zip Code:**
Vehicle & Insurance Information for Vehicle Used to Transport *(please attach a copy of your insurance card. The vehicle used to transport the client must be listed on the insurance policy).*		
Vehicle Identification Number (VIN):	**License Tag:**	
Auto Insurance Policy:	**Policy Issue Date (MM/DD/YYYY):**	**Policy Exp. Date (MM/DD/YYYY):**

Signature of ITP _______________________ **Date** _______________

Client/ITP Information Page

If you are driving yourself or family members only, fill out **Section 1 and leave Section 2 blank**.

If you are driving a person other than yourself or a family member, fill out **Section 1 and Section 2**.

<table>
<tr><th colspan="4">Section 1 (Facts About the Person You Will be Driving)</th></tr>
<tr><th>Client Name:</th><th>Medicaid ID #:</th><th>Client DOB (MM/DD/YYYY):</th><th>Relationship to ITP:</th></tr>
<tr><td></td><td></td><td></td><td>☐ Family Member
☐ Non-Family Member
☐ Self</td></tr>
<tr><th colspan="4">Section 2 (Facts about the ITP)</th></tr>
<tr><td colspan="3">Are you currently charged with or have you even been convicted of a crime (excluding Class C misdemeanor traffic citations)?

“Convicted” means that:
(a) A judgment of conviction has been entered against an individual by a Federal, State or local court, regardless of whether:
(1) There is a post-trial motion or an appeal pending; or
(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
(b) A Federal, State or local court has made a finding of guilt against an individual;
(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual, or
(d) An individual has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.</td><td>Check One:

☐ Yes
☐ No</td></tr>
<tr><td colspan="4">If Yes, fully explain the details including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of (attach additional sheets if necessary).</td></tr>
</table>

Terms and Condition of Participation

1. Before an ITP drives a client, the client must get approval for the ride from MTM, Inc. The client must call 1-855-687-4786 to get this approval prior to the trip otherwise the ITP will not get paid.
2. The client must have the doctor sign the ITP Service Contract and the ITP must sign the ITP Service Contract.
3. The mileage reimbursement (payment) amount is based on a mileage calculation computed by MTM, Inc. using a nationally recognized system of the shortest distance of the trip and not on the number of clients who are given a ride. The ITP will be paid based on the determined mileage at the vehicle mile rate set by the Texas Legislature for state employees that is in effect at the time of the ride.
4. All payments to an ITP will be reported to the Internal Revenue Service (IRS).
5. The ITP must maintain a current and valid driver's license, vehicle insurance, vehicle inspection and vehicle registration during each ride.
6. The claim form must be submitted within 95 days from the date of the ride.

Attestation:

I attest that I have read the terms and conditions of participation as an Individual Transportation Participant (ITP) and that the information provided in this application is true and correct. I understand that I must comply with the terms and conditions of participation and maintain documentation to support any mileage reimbursement claim and that HHSC or MTM, Inc. reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.

____ ______________________

Signature of ITP **Date**

Electronic Funds Transfer (EFT)

To enroll in EFT, complete the section below and attach a voided check or a signed letter from your bank on bank letterhead.

Type of Authorization:		
☐ New	☐ Change	
Last Name:	**First Name:**	**Middle Initial:**
Address		
Number/Street:	**City, State:**	**Zip Code:**
Telephone Number:		
( )		
Bank Name:	**Bank Telephone:**	
	( )	
Bank Address		
Number/Street:	**City, State:**	**Zip Code:**
ABA/Transit Number (Routing):	**Bank Account Number:**	
Account Type (*Check one)*		
☐ Checking	☐ Savings	

I hereby authorize MTM. Inc. to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I understand that I am responsible for the validity of the information on this form. If the company erroneously deposits funds into my account, I authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited.
I understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.
I will continue to maintain the confidentiality of records and other information relating to client in accordance with applicable state and federal laws, rules, and regulations.

Signature:	**Date:**

Please retain a copy for your records. All forms must be mailed or faxed to:
MTM, Inc.
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

Fax Number: 888-407-0936/**Web Mail:** txgmr@mtm-inc.net