Medicaid Transportation Assessment

Section A: Identifying Information

Casehead Name ______________________________ **County Case #**____________________

Date of Initial Request/Assessment: ____________________

Mailing Address ______________________________ **Physical Address:** __________________________

______________________________ __________________________

Phone: ____________________ ______________________ __________________________

Home **Work** **Other**

Recipient Name	Medicaid ID #	Program/Category	Presumptive Eligibility #
☐ Medicaid Denied Reason _________	☐ Authorized Medicaid Cert. Period ____________	☐ NEMT Approved ☐ NEMT Denied Reason______________	☐ Date DHB-5024 provided to A/R_________

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Section B: Assessment of the A/R's Need for Transportation

1. Do you have access to a vehicle that can be used to get to and from your medical appointments? ☐ Yes ☐ No
   ☐ Sometimes (Explain) ____

2. How have you been getting to your medical appointments? (Check all that apply)
   - ☐ Drive yourself
   - ☐ Friend/relative provides transportation
   - ☐ Bus/Taxi
   - ☐ Transportation services from an agency such as DSS, Health Department, Council on Aging, etc.
     Name of agency ____

3. Do you live within walking distance of a bus or van route? ☐ Yes ☐ No

4. Is there a reason why the source you have been using can no longer transport you to your medical appointment?
❑ Yes ❑ No Explain: _____

How long are these circumstances expected to continue? _____

Based on the information above, the a/r:

❑ Meets the requirements for assistance with medical transportation.
❑ Does not meet the requirements for assistance with Medicaid transportation because: _____
_____

Section C: A/R's Special Transportation Needs

Medical Needs	Other Needs
❑ Attendant*****-- Name: _____	❑ Accompanying Adult for Minor Child – Name: _____
❑ Wheelchair***** – Type: _____	❑ Additional Children – Number _____ Names _____ _____
❑ Cane/Crutches/Walker*****	
❑ Scooter*****	
❑ Compact Portable Oxygen Tank*****	❑ Child Car Seat – Type:
❑ Service Animal*****	❑ Accompanying Translator? Yes or No
❑ Disorientation***** ❑ Hearing***** ❑ Sight*****	
Other:*****_____	Other: _____

***** Complete DHB-5048, Medicaid Transportation Exception Verification (unless the special need is obvious).

Section D: Documentation and Approval

Request for transportation assistance is: ❑ Approved ❑ Denied

Does the a/r need to be transported to a provider outside of the county on a routine basis? ❑ Yes ❑ No
If so, why? (example, "enrolled in Carolina Access and nearest provider is in adjacent county.") _____
_____

Are there are any time limitations on the need for transportation special needs assistance. _____
Date DHB-5048 received when applicable _____

Has the a/r has been given the No-Show policy and instructions how to request transportation? ❑ Yes ❑ No

Section E: Upcoming Medical Appointments

Does the recipient have an upcoming medical appointment for which transportation is needed?
❑ Yes ❑ No

Date and Time of Appointment	Name and Address of Provider	Return Trip Yes	Return Trip No	Arrangements	Pick Up Time AM/PM

Section F: Assessment Sign-Off

Completed By: _____	Date: _____
Agency: _____	Telephone No.: _____