

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 #
<input type="checkbox"/> Medicaid Denied Reason _____	<input type="checkbox"/> Authorized Medicaid Cert. Period _____	<input type="checkbox"/> NEMT Approved <input type="checkbox"/> NEMT Denied Reason _____	<input type="checkbox"/> Date DMA-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
<input type="checkbox"/> Attendant*-- Name: _____	<input type="checkbox"/> Accompanying Adult for Minor Child – Name: _____
<input type="checkbox"/> Wheelchair*– Type: _____	<input type="checkbox"/> Additional Children – Number _____ Names _____ _____
<input type="checkbox"/> Cane/Crutches/Walker*	
<input type="checkbox"/> Scooter*	
<input type="checkbox"/> Compact Portable Oxygen Tank*	<input type="checkbox"/> Child Car Seat – Type: _____
<input type="checkbox"/> Service Animal*	<input type="checkbox"/> Accompanying Translator? Yes or No
<input type="checkbox"/> Disorientation* <input type="checkbox"/> Hearing* <input type="checkbox"/> Sight*	
Other:* _____	Other: _____

* Complete DMA-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 any time limitations on the need for transportation special needs assistance. _____
 Date 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		Arrangements	Pick Up Time AM/PM
		Yes	No		

Section F: Assessment Sign-Off

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