



**Section C: Selection of Medical Provider**

1. Name of medical provider selected? \_\_\_\_\_  
\_\_\_\_\_

Reason Selected (Check all that apply)

- Provider accepts Medicaid
- Carolina Access/Managed Care Participant
- Ongoing treatment program
- Personal Preference
- Other \_\_\_\_\_
- PCP Referral
- Specialist
- Distance

1. Is the medical provider appropriate for the a/r's needs?
- Yes Approve transportation to this provider. Go to Section D
  - No Inform the a/r that he may not be eligible for transportation to this provider
2. Is the a/r willing to change providers to receive transportation assistance?
- Yes Arrange transportation when new appointment is made.
  - No Deny the request for assistance with transportation. Send the DMA-5024 Notice of Medicaid Transportation.

**Section D: Method of Transportation**

Document the least expensive means of transportation suitable for the a/r's needs. Provide a detailed explanation of any special needs used to determine "suitable" transportation.

- Gas Vouchers \_\_\_\_\_
- City Bus \_\_\_\_\_
- County Coordinated Transportation System \_\_\_\_\_
- Cab/Taxi Service \_\_\_\_\_
- Personal Vehicle \_\_\_\_\_
- Free Transportation (i.e. family, friend, etc.) \_\_\_\_\_
- Other \_\_\_\_\_

**Section E: Evident Hardship Referral**

Explain hardship communicated by recipient \_\_\_\_\_  
\_\_\_\_\_

Evident hardship verified:  Yes  No  
Verification: \_\_\_\_\_  
\_\_\_\_\_

Referral Needed:  Yes  No If Yes, Referral sent to: \_\_\_\_\_ Date: \_\_\_\_\_

**Section F: Approval of the Request for Transportation Assistance**

Approved:  Individual Trip(s) From \_\_\_\_\_ To \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_

Series of Appointments From \_\_\_\_\_ To \_\_\_\_\_

Blanket Approval From \_\_\_\_\_ To \_\_\_\_\_  
 Method: \_\_\_\_\_  
 Related travel needs: \_\_\_\_\_

**Section H: Special Medical Needs**

Attendant - Name: \_\_\_\_\_

\*Medical Necessity Verified By: \_\_\_\_\_

Accompanying Adult for Minor Child – Name: \_\_\_\_\_

Additional Children (No Child Care Available) – Number \_\_\_\_\_

Names: \_\_\_\_\_

Child Car Seat – Type: \_\_\_\_\_

Cane/Crutches/Walker

Compact Portable Oxygen Tank

Scooter

Service Animal

Wheelchair – Type: \_\_\_\_\_

Translator – Name: \_\_\_\_\_

Other \_\_\_\_\_

**Section I: Other Special Considerations**

Check all that apply:

Disorientation

Hearing

Sight

Other: \_\_\_\_\_

**Section G: Case Documentation of Scheduled Transportation Services**

Date and Time of Appointment	Name and Address of Provider	Return Trip		Arrangements	Date A/R Notified	Pick Up Time AM/PM
		YES	NO			

**Section J: Assessment Sign-Off**

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