



L.O.N.

Level of Need Assessment

Facility Fax: _____

Dear Medical Professional:

Our office has received a request for transportation to a Medicaid Covered Service; please fill the Level of Need assessment form out in its entirety. This form will be used to determine the recipient's most appropriate mode of transportation based on their functional abilities and limitations. Please provide any information that will assist us in identifying the mode of transportation that best fits the recipient's needs.

Recipient Info	First Name:	Last Name:	Date of Birth:	
	Medicaid #:	Trip Number:	Plan Id:	
	Address:	City:	State:	Zip:
Diagnosis and Transport Info	Diagnosis (MUST PROVIDE):		Diagnosis is: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Through (date): _____	
	Is recipient able to use public transportation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Abilities and Equipment	Recent Hospitalizations/Surgeries (MUST PROVIDE):			
	Can patient ambulate independently?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Can patient ambulate a 1/2 mile?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does patient use any of the following assistive devices? <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Electric Wheelchair/Scooter <input type="checkbox"/> Manual Wheelchair •Can patient self propel? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Can patient self-transfer into vehicle?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is the patient bed bound and not able to sit in a wheelchair?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does patient require monitoring by a certified EMT or paramedic during transport?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cognitive Abilities	What is the patient's cognitive ability? <input type="checkbox"/> Alert & oriented (i.e. place, time) <input type="checkbox"/> Alert & mildly confused (i.e. place, time) <input type="checkbox"/> Confused (i.e. dementia, alzheimers) Comments:			
Sensory Abilities	Is the patient legally blind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Physician Info	Printed Name:		Phone #:	
	Signature:		NPI #:	

✓ Questions? Please call the Care Management Department toll free at 1-888-561-8747

Please fax this completed form to: 1-877-406-0658 ATTN: Care Management

This form must be received no less than 1 business day prior to the appointment time or transportation cannot be arranged.