Access2Care

Travel Assessment Form

Healthcare Plan ____ **Healthcare ID#** ___________________________

LAST NAME ______________________________ FIRST NAME ______________________________ MI ___________

DOB____/______/______TELEPHONE # (________)_________________________________TDD#________________

Contact information of person requesting services on behalf of member:

Name: ___________________________ Relationship:______________________ Phone: (___)_________________

MEDICAL VERIFICATION

Federal requirements state that non emergent medical transportation services be rendered with the least cost, most appropriate level of service. The following information is requested to determine the most appropriate level of transportation service for the above named individual. Unless the participant has a medical impairment preventing them from using public transportation, this will be the primary level of service authorized under this program. Qualified medical personnel must attest to override necessity (service coordinators, social workers, may not make medical determinations). In order to process this applicant's request to become eligible for any level of service other than bus, the section below must be completed by a licensed physician.

AMERICANS WITH DISABILITIES ACT (ADA) CATEGORIES: *(Check the categories of eligibility that you recommend should apply.)*

[ ] The individual is unable, as a result of a physical or mental impairment, and without the assistance of another individual, *(except the operator of a wheelchair lift or other boarding device),* to board or ride, an accessible bus or rail vehicle.

[ ] The individual has a specific impairment-related condition which prevents the individual from traveling to or from: public bus; public rail; and/or fixed-route stops/stations.

[ ] Check here, if none of these categories apply.

RECOMENDED LEVEL OF TRANSPORTATION SERVICE: *(select one)*
[ ] Public Transportation (bus/rail) [ ] Ambulatory (sedan/taxi) [ ] Other___________________ (*please specify)*

IS THIS IMPAIRMENT: *(select one)* [ ] Permanent [ ] Temporary

If temporary, date of disability ____________________________ Length of recovery ______________________________

Comments____

BASED ON THE INDIVIDUAL'S DISABILITY, DO YOU RECOMMEND A PERSONAL CARE ATTENDANT ACCOMPANY THE PARTICIPANT ON EACH TRIP? [ ] Yes [ ] No

INDICATE THE TASKS RELATED TO USING PUBLIC TRANSIT THAT THE PARTICIPANT WOULD HAVE SIGNIFICANT DIFFICULTY ACCOMPLISHING. CHECK ALL THAT APPLY:

[ ] No limitations that would prevent the use of bus/rail service

[ ] Enduring warm or cold weather

[ ] Waiting thirty minutes

[ ] Recognizing a bus stop

[ ] Identifying a public transit vehicle

[ ] Recognizing destinations if stops are marked

[ ] Understanding/handling bus fare *(boarding passes are provided)*

[ ] Handling changes in normal routine

[ ] Climbing 1-3 Steps

[ ] Walking more than ______ blocks *(Must stipulate number of blocks)*

These limitations apply: [ ] always [ ] usually [ ] occasionally [ ] rarely

COMMENTS: ____

____

____

Practitioner Information:

Print or Type Name of Physician ____________________ **Signature** ____________________

State License # ____________________ **Telephone**____________________

Office Address ____

City ____________________ **State** __________ **Zip Code** ____________________

Please return completed form to:
Access2Care
Attn: Public Transportation Services
Fax: 1-866-253-5250
Email: businfo@evhc.net
Mailing Address:
16331 Bay Vista Drive
Clearwater, FL 33760

Section 3 – RESULTS OF ASSESSMENT

[ ] NEW ELIGIBILITY [ ] REDETERMINATION PRIMARY LOS ASSIGNED: ____________________

[ ] PCA NEEDED [ ] LOS VOLUNTARY EXPIRATION DATE: ____________________

SPECIAL INSTRUCTIONS: ____

DATE RECEIVED: ____________________ RECEIVED BY: ____________________