



L.O.N.

Level of Need Assessment Form

Facility Fax:

Dear Medical Professional:

Our office has received a request for transportation for one of your patients. Please fill out this Level of Need Assessment form completely and provide any supporting information as needed. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations.

Patient Info	First Name:		Last Name:		Date of Birth:	
	Medicaid #:		Phone #:		Trip #:	
	Address:		City:		State:	Zip:
Diagnosis and Transport Info	Diagnosis that supports transportation limitations (MUST PROVIDE):				Diagnosis is: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Through (date):	
	Recent Hospitalizations/Surgeries (MUST PROVIDE):					
Living Arrangements	<input type="checkbox"/> Lives alone or with family/friends <input type="checkbox"/> Nursing facility <input type="checkbox"/> Group home <input type="checkbox"/> Residential rehab facility Comments:					
	Number of steps at residence: _____					
Physical Abilities and Equipment	Can patient ambulate independently? <input type="checkbox"/> Yes. (Max. Distance: _____) <input type="checkbox"/> No					
	Does patient use any of the following assistive devices? <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Portable Oxygen <input type="checkbox"/> Service Animal <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Electric Wheelchair					
	Does patient require assistance of trained personnel for safety? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Can patient self propel in wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No			Can patient self-transfer from wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Do environmental factors like heat or cold affect the patient's mobility? <input type="checkbox"/> Yes (please explain): _____ <input type="checkbox"/> No					
	Has there been a decline in functionality? <input type="checkbox"/> Yes (please explain): _____ <input type="checkbox"/> No					
Cognitive Abilities	Does the patient have problems with any of the following? If yes, give a rating for each category, with 1 being mild impairment and 5 being severe impairment.				Additional comments:	
	Alertness		<input type="checkbox"/> No <input type="checkbox"/> Yes, rating (1-5): _____			
	Memory Issues		<input type="checkbox"/> No <input type="checkbox"/> Yes, rating (1-5): _____			
Confusion		<input type="checkbox"/> No <input type="checkbox"/> Yes, rating (1-5): _____				
Able to remove self from unsafe situation?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Sensory Abilities	Vision	<input type="checkbox"/> Cataracts <input type="checkbox"/> Legally blind Comments:				
	Speech & Hearing	Deaf? <input type="checkbox"/> Yes <input type="checkbox"/> No		Able to communicate needs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical Professional Info	Printed Name:				Phone #:	
	Signature:		Date:		NPI #:	

Questions? Please call the Care Management Department 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 72 hours prior to the appointment time or transportation cannot be arranged.