**State Administered NEMT Transportation Level of Need (LOS) Assessment**

**After Hours Submissions (6pm to 7am) Fax to KEPRO Toll Free Fax number: 844-673-8033**

**State Administered Non-Emergency Medical Transportation (NEMT)** requiresdriver to assist the member door-to-door or door-thru-door (station-to-station). This includes but is not limited to assistance from inside of the residence to enter and exit to assisting the client to enter and exit the health care facility up to and from the appropriate medical appointment desk.

|  |  |  |  |
| --- | --- | --- | --- |
| **Member Name:** | **DOB:** | | MA #: |
| **Information provided by:** | **Relationship to Member:** | | **Call Back #’s:**  **Home:**  **Cell:**  **Other:** |
| **Client Address:** | | **Language:**  **Interpreter Name:**  **Interpreter Agency:** | |

1. **Certification request type:** **\_\_\_\_** New Certification **\_\_\_\_** Recertification
2. **Level of Service Requested:** **\_\_\_\_** Assisted **\_\_\_\_** Ramp/Lift Equipped **\_\_\_\_** Stretcher
3. Primary Care Physician: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (Not required for certification)

Facility: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Fax #: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Primary Condition/Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Condition/Diagnosis:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Condition Expected to Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6.** Reason for transportation:

Medical Appointment(s)  **\_\_\_\_** Hospital Discharge\* **\_\_\_\_** Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***6.1. \*If Hospital Discharge, please complete questions below:***

Where is patient discharging to?

**\_\_\_\_** Skilled Nursing Facility **\_\_\_\_** Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7.** Is this a one-time appointment **\_\_\_\_** or a series of appointments **\_\_\_\_**?

**8 .** Can the patient ambulate independently? **\_\_\_\_** YES *\*complete below* **\_\_\_\_** NO

\*Estimated distance*(w**ith mobility aid if applicable)*

**\_\_\_\_** A few feet **\_\_\_\_** Up to 9 blocks **\_\_\_\_** No limitations

**9** Does the patient use a mobility aide? \_\_\_\_ YES \**complete below* \_\_\_\_ NO

9.1\*Type of mobility aid used?(MCWB01114_0000[1]all that apply)

**\_\_\_\_** Walker  **\_\_\_\_** Cane **\_\_\_\_** Crutches **\_\_\_\_** Wheelchair\* **\_\_\_\_** Scooter\* (\**complete below*)

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

9.2 \*Type: **\_\_\_\_** Manual **\_\_\_\_** Electricrigid or foldable

9.3 Can the patient transfer into vehicle independently? **­­­­ \_\_\_\_** YES **\_\_\_\_** NO

9.4 Can the patient maneuver their wheelchair independently? **\_\_\_\_** YES **\_\_\_\_** NO

9.5 Estimated distance? **\_\_\_\_** A few feet **\_\_\_\_** Up to 9 blocks **\_\_\_\_** No limitations

**10 .** If the patient is able to sit up, how long can they sit up?

**\_\_\_\_** Length of time **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_** Unlimited or more than a few hours

**11 .** Does the patient’s physical or mental condition affect their ability to use public transportation or taxi?

**\_\_\_\_** YES**\_\_\_\_** NO

***If yes, describe*:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**12 .** Does the patient require assistance from the transportation driver: (MCWB01114_0000[1]all that apply)

**\_\_\_\_** Inside their residence to enter and exit **\_\_\_\_** Transfer in/out of vehicle

**\_\_\_\_** Inside the medical facility to enter and exit **\_\_\_\_** Does not require assistance

**13 .** Does the patient require assistance opening doors at the following:(MCWB01114_0000[1] all that apply)

**\_\_\_\_** Medical facility- entrance **\_\_\_\_** Medical facility- inside (beyond entrance)

**\_\_\_\_** Vehicle Doors **\_\_\_\_** Does not require assistance

**14 .** Does anyone accompany the patient to his or her medical appointments? **\_\_\_\_** YES **\_\_\_\_** NO

**15.1** Whom: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** How often: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

15.2 What assistance does the attendant provide? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**15 .** How does the patient get to other non-medical locations? (MCWB01114_0000[1]all that apply)

**\_\_\_\_** Public Transportation **\_\_\_\_** Ride from family, friend, or caregiver

**\_\_\_\_** Drives his/herself **\_\_\_\_** Ride from resident staff

**\_\_\_\_** Unknown

**16 .** Why will that transport process not work for medical appointments? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**17 .** How does the patient get around within the home, medical facility, or community? (MCWB01114_0000[1]all that apply)

**\_\_\_\_** Ambulates with/without assistive devices independently

**\_\_\_\_** Ambulates but requires physical assistance from another person

**\_\_\_\_** Uses a wheelchair/scooter independently

**\_\_\_\_** Uses a wheelchair w/assist from another person

**18 .** Any additional information, comments or concerns:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Administered NEMT LOS Assessment Determination:**

**\_\_\_\_** Approved Certification Timeframe/Dates: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Level of transport certification: **\_\_\_\_** Assisted **\_\_\_\_** Ramp/Lift Equipped **\_\_\_\_** Stretcher

­­­­**\_\_\_\_** Denied Reason for Denial: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**