



modivcare



West Virginia Operations
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LEVEL OF NEED ASSESSMENT FORM

Modivcare has received a request for transportation for one of your patients. Please complete this Level of Need Assessment Form and provide any supporting information where applicable. This form will be used to determine the most appropriate mode of transportation (level of service) based upon your patient's functional abilities and/or limitations.

Member Information:

Today's Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_ DOB: \_\_\_\_\_

Public Transportation Verification: (Please check all that apply; must be completed by medical provider)

- Member is physically/cognitively ABLE to walk 1/2 mile.
Member is physically/cognitively ABLE to use public transportation (e.g. bus or other public mass transit).
Member is physically/cognitively ABLE to use public transportation ONLY if accompanied by an aide/companion. (If so, Modivcare pays for the aide's/companion's fare, but Modivcare does not provide the aide/companion.)

If the Member is UNABLE to use public transportation, please choose one transportation level of service appropriate for the Member:

- Member is AMBULATORY - (curb to curb service; can walk without assistance).
Member is AMBULATORY with an assistive device (cane, walker, etc.). How many feet can patient walk using this equipment? \_\_\_\_\_
Member requires a WHEELCHAIR. \*Type: Manual / Electric / Scooter (please circle one)
\*(Modivcare does not provide wheelchairs or scooters.)

If Member requires a wheelchair, please provide:

Member's Height \_\_\_\_\_ Member's Weight \_\_\_\_\_ Number of Stairs at Pick Up Address \_\_\_\_\_

- Member is able to stand/transfer without assistance.
Member is able to stand/transfer with the assistance of one person.

\*\*REQUIRED\*\* Please describe specifically why the member is unable to use public transportation. (Do not use any number codes and please print.)

Is the period of incapacity permanent? Yes / No. If not, expected expiration date of restrictions: \_\_\_\_\_

Medical Provider Information:

A medical provider is defined as a Physician, Physician's Assistant, Advance Practice Registered Nurse/Nurse Practitioner, or Registered Nurse who has provided direct medical care to the Member.

PRINTED NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

SIGNATURE OF MEDICAL PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_\_