Date:

Dear:

LAND OF SKY TRANSPORTATION RESOURCE CENTER
A PROGRAM OF LAND OF SKY REGIONAL COUNCIL

Non-Emergency Medicaid Transportation
339 New Leicester Hwy., Suite 140
Asheville, NC 28806
p: 828.552.5486 | f: 828.552.4234
w: landofsky.org

This letter is being sent to you so I may:

☐ **Assess your request for Medicaid Transportation Services**

☐ **Complete your review for Medicaid Transportation Services.**

These services are to be used for your medical appointments only. Please read the statement below and complete all forms. Once you have signed the bottom of this letter and completed all forms (for each person you are applying for), return the package to me in the enclosed stamped envelope.

If I do not hear from you by _____ which is 10 days from the date of this letter, I'll assume you no longer need Medicaid Transportation services and your case will be closed.

Sincerely,

828-552-5486
Non-Emergency Medicaid Transportation Caseworker

(PLEASE NOTE: A COPY OF THE "GENERAL INFORMATION AND GUIDELINES" HAS BEEN ENCLOSED FOR YOU TO KEEP. If you have any questions about these guidelines, please contact me at the phone number above.)

I have read and understand the "General Information and Guidelines" for the Buncombe County Medicaid Transportation Program. I agree to abide by all rules and regulations listed in these guidelines. Once I am approved for Medicaid Transportation Services, I will contact my transportation worker if any change occurs in my home. These changes could be, but are not limited to, change of address, change in telephone number, or change in physician or medical provider.

_____ _____

Client Signature Date

COMPLETE THIS FORM ENTIRELY

Name:_____ **Phone Number**: _____

Social Security #:_____ **Date of Birth**: _____

Mailing Address: _____

City/State_____ Zip:_____

Home Address: _____

City/State_____ Zip:_____

Emergency Contact Name:_____

Relationship: _____Phone Number _____

1. Do you have access to a vehicle that can be used to get to and from your medical appointments?
   ☐ Yes ☐ No ☐ Sometimes (Explain) _____
2. How have you been getting to your medical appointments? (Check all that apply)
   ☐ Drive Yourself ☐ Friend/Relative provides transport ☐ Bus/Taxi
   ☐ Transportation services from an agency such as DSS, Health Department, Council on Aging, etc.
   Name of Agency: _____
3. Do you live within walking distance of a bus stop? ☐ Yes ☐ No
   If yes, how may blocks would you have to walk to get to the nearest bus stop? _____Blocks
   If yes, do you have a health condition that would prevent you from riding the bus?
   _____
4. Is there a reason why the source you have been using can no longer transport you to your medical appointments?
   ☐ Yes ☐ No If yes, explain: _____
5. How long are these circumstances expected to continue: _____

Special Transportation Needs: (Check any of these items you use while traveling)

6. Is it medically necessary for an attendant to travel with you: ☐ Yes ☐ No
   Name of Attendant: _____
   ☐ Wheelchair (type: ☐ motorized ☐ manual) Do you have a ramp? ☐ Yes ☐ No
   ☐ Cane ☐ Walker ☐ Crutches ☐ Scooter
   ☐ Compact Portable Oxygen Tank ☐ Respirator ☐ Service Animal
   ☐ Accompanying Adult for Minor Child Name:_____
   ☐ Child Car Seat (type) _____
   Accompanying Translator ☐ Yes ☐ No Name:_____
   Do you have trouble with: ☐ Disorientation ☐ Hearing ☐ Sight ☐ Speech ☐ Other _____
7. **In order for you to receive Medical Transportation, we need you to list the names of all doctors or medical providers you use. (Please note: If there are no providers listed, transportation may be denied.)** _____

_____

_____ _____

Signature Date

Any information on this form will remain confidential Revision Date 3/29/16