West Virginia Operations
602 Virginia Street East
Charleston, WV, 25301
844-889-1941
Fax: 855-882-5998

LEVEL OF NEED ASSESSMENT FORM

LogistiCare 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 ½ 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, LogistiCare pays for the aide's/companion's fare, but LogistiCare **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)
*(*LogistiCare 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:** _____