NYS DOH Care Plan Grid for Transportation of TBI Waiver Participants

1. Waiver Participant Information

Last Name _____ First Name _____ Medicaid ID # _____ DOB _____ /_____ / _____
County _____ Address _____ City _____ State _____ Zip code _____

2. Medical Provider Information

Medical Provider _____ NPI _____ Telephone _____ Fax _____
Medical Provider Address _____ City_____ State _____ Zip code_____

3. Transportation Service Requested

Service Coordinator _____ Verification Form Submitted Yes / No

4. Care Grid

Type of Transportation Service Needed	Trip Destination/Location	Start Date/ End Date	Frequency	Round Trip or One Way	Trip Cost*	Annual units for waivered services only

* Trip cost is derived from using the NYS Fee schedule at http://www.emedny.org/ProviderManuals/Transportation/index.html. A LogistiCare (LGTC) representative may assist you in determining the correct fee for the Waiver Participant's level of service and with additional trip cost. To calculate daily trip cost. Add base rate and additional trip cost. Trip costs for reoccurring daily services are generally fixed costs. When you total transportation costs, keep in mind that most transportation is for round trips.

Transportation for Medicaid Covered Services or approved waivered services must be prior authorized by LGTC on behalf of NYSDOH under 18 NYCRR §505.10. A current service plan for the Waiver Participant must be submitted to LGTC. **This transportation grid must be completed and submitted to LGTC with a completed service plan for waivered services transportation. All waivered service transportation must be listed in a Waiver Participant's Service plan**. Completing this form does not schedule transportation for a Waiver Participant. It allows LGTC to ensure that waivered services transportation information is clear and reflects current NYS approved Medicaid transportation cost for service. Service plans may need to be amended or updated if Medicaid transportation levels of service and cost are not included in the Waiver Participant's service plan and accurately reflect NYS approved transportation rates for non-emergency Medicaid transportation. Information that is inaccurate or not up to date may cause a delay in LGTC being able to prior authorize transportation until the service plan is updated and this form is completed.

Date _____ Completed By_____ Telephone_____ Email_____ Fax_____

Date _____ MAS Staff Approver _____ Telephone_____ Email_____ Fax_____

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Instructions

1. **Waiver Participant Information**. Complete the Waiver Participant Information. The Medicaid ID # is the participant's Medicaid Number. The County is the county that is fiscally responsible for the participant's Medicaid.

2. **Medical Provider Information.** Complete the Waiver Participant's medical provider information. This might be the Waiver Participant's primary care physician. Please be sure to include all requested information.

3. **Transportation Service Requested.** List the service coordinator's name and if a Verification Form has been submitted to LogistiCare Solutions (LGTC) with the Waiver Participant Information. A Verification Form is required to be on file with LGTC for each Waivered Services Participant that requires ambulette service or a higher level of service. If the participant medical condition will require permanent use of a wheelchair, note the verification form for permanent need. The Verification Form is available at www.longislandmedicaidride.net. Have the ordering medical provider complete the Verification Form and return it with the Care Grid.

4. **To complete the Care Grid**;
    a. List Type of Transportation Service Needed required, for example; wheelchair
    b. List the complete trip destination address the participant will be taken to. Enter the appointment time and the return pickup time if known. Return pickup times can be "will call". The participant should be ready for pickup, one hour prior to the appointment time.
    c. Waivered transportation locations are subject to NYSDOH approval.
    d. The pickup location for each trip for the participant will be the address listed in the Waiver Participant Information unless otherwise noted. The pickup address will also be the address the participant is returned to after the trip unless otherwise noted.
    e. Enter the start date for the trip. If the transportation is ongoing (standing order) list the start date and the end date for the trip.
    f. All standing orders scheduled with MAS are for a maximum of 6 months in duration and must be renewed every 6 months, ten business days prior to January 1st and July 1st each year.
    g. Frequency; enter the days of the week transportation is required. For example (M-W-F).
    h. RT/OW. Enter RT if the trip is a round trip. Enter OW if the trip is one way only.
    i. Enter the trip cost. If needed you may call an MAS supervisor to assist you with calculating the trip cost. The trip cost is derived from NYS approved transportation rates and may be a calculation of a base rate, approved mileage and other approved NYS costs.
    j. Annual units for waivered services only. List the total cost of waivered services being approved annually. The number of trips provided for waivered services annually may be limited based on the budget units or dollar amount approved.

5. Enter the name, telephone number, email address and fax number of the person submitting the Care Plan Grid.