FOR OFFICE USE ONLY: Date: _____

____ Approved – Local ____ Denied – Local

____ Approved – Out of Area ____ Denied – Out of Area

____ Free programs/services offered by city, county, or state agencies can provide transportation for this applicant: _____

_____

Talbot County, Maryland

MEDICAID TRANSPORTATION APPLICATION

(TO Be Filled Out By Applicant, Guardian, or Representative)

Medicaid funded transportation is available to eligible applicants for non-emergency, medically necessay appointments. Applicants must have, and provide, their current Federal Medicaid/Medical assistance number. The applicant must lack access to, or be unable to utilize other public transportation, and must have **NO OTHER MEANS OF TRANSPORTATION TO THESE NECESSARY MEDICAL APPOINTMENTS.**

The Talbot County Heath Department is responsible for verifying recipient eligibility through Medicaid, medical providers, and other resources as to the necessity of transportion to ensure eligible clients receive services in an efficient and cost-effective manner.

APPLICANT INFORMATION

****ALL QUESTIONS MUST BE ANSWERED COMPLETELY****

Applicant's Name: _____ M. A. Number: _____

Physical Address: _____ Date of Birth: _____

Mailing Address (if Different): _____ Home Phone: _____

City: _____ Alternate Phone: _____

State: _____ Zip Code: _____

1. This application is being submitted for (CHECK ONE): ___Self ___ Minor Child ___ Adult Child ___ Adult Relative ___ Other (Please explain): _____

   A. If this application is being filled out by someone other than the applicant, please provide the following:

      Name: _____ Relationship: _____

      Address: _____ Telephone: _____

2. Why is the applicant requesting Medicaid Transportation? _____
3. Does the applicant have a current Driver's License? ___ YES ___ NO
4. Does the applicant own a vehicle?: ____ YES ____ NO

   If "YES" explain why the applicant is unable to use the vehicle: _____
5. Does the applicant have any relatives, friends, or neighbors who own a vehicle that can be made available to transport them to medical appointments?: ___ YES ___ NO

   If "YES" Please explain: _____

6. How does the applicant get to Medical Appointments presently?: _____

7. Has the applicant ever used a volunteer or a public or private agency to obtain transportation to a medical appointment?: ____ YES ____ NO

   If yes, please provide what mode was used: _____

8. Has the applicant used Public Transportation (ex.community bus) to get to appointments?: ____ YES ____ NO

9. How does the applicant get to other appointments (ex.grocery store, church, other activities)?: _____

10. Can the applicant walk to any medical appointment?: ____ YES ____ NO

    If yes, please list the provider(s): _____

    If no, please explain: _____

11. Is the applicant employed?: ____ YES ____ NO

    If "YES" how does the applicant get to and from work? _____

12. Does the applicant have a mental or physical disability?: ____ YES ____ NO

    If yes, please describe the disability: _____

13. Does the applicant require an attendant?: ____ YES ____ NO

    If "YES" please explain: _____

14. Does the applicant have a physical disability that requires the use of a wheelchair?: ____ YES ____ NO

15. How close to the applicant's home is the primary care provider?: ____ ½ mile ____ 1 mile _____other: _____

16. How frequent are the applicant's medical appointments?: ____ weekly ____ monthly _____other: _____

17. Can the applicants medical appointments be rescheduled if transportation is not available?: ____ YES ____ NO

MEDICAL PROVIDER'S INFORMATION

Primary Care Physician/Clinic: _____

Address: _____ Phone Number: _____

City: _____ Zip Code: _____

Note: Your Primary Medical Care Provider must be located within the Talbot County Service Area, no further than 30 miles or 30 minutes from the client's home, in accordance with the guidelines of the state. Referrals to specialists must be made to the closest possible provider. For those enrolled in Health Choice, the MCO may be responsible for transporting the applicant to appointments if they or their doctor are referring to a specific service or provider located outside the service area as described above.

I CERTIFY THAT ALL THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT. I UNDERSTAND THAT ANY FALSE STATEMENTS MAY RESULT IN DENIAL OF MY APPLICATION FOR MEDICAID TRANSPORTATION. I FURTHER CERTIFY THAT I HAVE RECEIVED THE CLIENT HANDBOOK FOR THE TALBOT COUNTY MEDICAL ASSISTANCE TRANSPORTATION PROGRAM, AND IF APPROVED FOR TRANSPORTATION I AGREE TO FOLLOW THE RULES AND REGULATIONS AS SPECIFIED WITHIN.

Signature: _____ Date: _____

Print Name: _____

Filename: MA Transportation Application

TALBOT COUNTY
MEDICAL ASSISTANCE
TRANSPORTATION PROGRAM

Authorization for Release of Information

I, _____, hereby authorize and consent to the release of requested information, by Talbot County Medicaid Transportation Program, for confirmation of any and all scheduled medical appointment(s) with my physicians, medical facilities and/or medical services agencies for which I request transportation by the Talbot County Medicaid Transportation program; also, to confirm my attendance at such appointment(s) for which Medicaid Transportation services were provided.

Purpose of Release: The purpose of this release is solely for obtaining confirmation of appointments, specifically date and time of patient/client's appointments for which Medicaid Transportation is requested. In order to provide Medicaid Transportation services to eligible recipients the Program must verify validity of appointments with attending physician's offices, and any other medical facilities or agencies for which the patient/client requests to be transported.

The release expires on the expiration date of patient/client's eligibility for Talbot County Medicaid Transportation services.

I, _____ (print name), have read and understand the above statements. I also understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the medical office, medical facility, or agency providing the information, and a copy to the Medical Assistance Transportation Specialist.

_____ _____

Signature of Patient or Patient's Representative | Relationship to Patient (if not patient)

Date: _____

Print Name: _____ Date of Birth: _____

Address: _____ Telephone No.: _____

City: _____ State: _____ Zip: _____ Cell Phone No.: _____

TALBOT COUNTY
MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

MEDICAID TRANSPORTATION PROGRAM
NOTICE OF PRIVACY PRACTICIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED.

We may contact your doctor to verify your medical condition for Medicaid Transportation purposes only.

Any medical information provided to us concerning your diagnosis, symptoms, treatments, medical and/or doctors' visits, or any other detail regarding your healthcare is strictly confidential and will not be disclosed or used for any purpose other than determining your eligibility for the use of Medicaid Transportation services.

The Medical Assistance Transportation Program requests that you acknowledge receipt of this notice by signing and returning this form to the Medical Assistance Transportation Specialist of Talbot County.

Signature: _____ Date: _____

Print Name: _____

TALBOT COUNTY MEDICAL ASSISTANCE
TRANSPORTATION PROGRAM
100 S. Hanson Street
Easton, Maryland 21601
410-819-5609 or 410-819-5600
Fax 410-819-5683