Appropriate Level of Care

PATIENT INFO				
First Name		Last Name		
Date of Birth	Medicaid #	Phone #	Voucher #	
Address		City	State	Zip

Instructions

Dear provider, we are assessing the most appropriate level of care needed for the above-mentioned member. Please completely fill out, sign and fax this form to 855-621-8962. This form will be used to determine the member's abilities and limitations to assign the right vehicle, driver and care instructions.

DIAGNOSIS AND TRANSPORT INFO	
Diagnosis that supports transportation limitations (MUST PROVIDE)	Diagnosis is
	☐ Permanent ☐ Temporary Through (date):
Recent Hospitalizations/Surgeries (MUST PROVIDE)	

LIVING ARRANGEMENTS	
☐ Lives alone or with family/friends	☐ Nursing facility
☐ Group home	☐ Residential rehab facility
Comments	Number of steps at residence

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PHYSICAL ABILITIES AND EQUIPMENT								
Can patient ambulate independently?	☐ Yes (Max. Distance:)						☐ No	
Does patient use any of the following assistive devices?								
☐ Walker	☐ Crutches	☐ Cane	☐ Portable Oxygen					
☐ Service Animal	☐ Manual Wheelchair	☐ Electric Wheelchair						
Does patient require assistance of trained personnel for safety?							☐ Yes	☐ No
Can patient self-propel in wheelchair?							☐ Yes	☐ No
Can patient self-transfer from wheelchair?							☐ Yes	☐ No
Do environmental factors like heat or cold affect the patient's mobility?								
☐ Yes (please explain):								☐ No
Has there been a decline in functionality?								
☐ Yes (please explain):								☐ No

COGNITIVE ABILITIES								
Does the patient have problems with any of the following? If yes, circle a rating for each category, with 1 being mild impairment and 5 being severe impairment.								Additional comments:
Alertness	☐ No	☐ Yes	1	2	3	4	5	
Memory Issues	☐ No	☐ Yes	1	2	3	4	5	
Confusion	☐ No	☐ Yes	1	2	3	4	5	
Able to remove self from unsafe situation?							☐ Yes	☐ No

SENSORY ABILITIES						
Vision	☐ Cataracts	☐ Legally blind	Comments			
Speech & Hearing	Deaf? ☐ Yes	☐ No	Able to communicate needs?	☐ Yes	☐ No	

MEDICAL PROFESSIONAL INFO			
Printed Name		Signature	
NPI #		Phone #	

This form must be faxed from the provider's office. If you have any questions, please call Alivi at **1-888-863-0248.**