Public Transportation Voucher

alivi

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

Instructions

Dear provider, the above-mentioned patient has submitted a request for a public transportation pass. Please completely fill out and sign this Public Transportation Voucher and fax it to (305) 742-2561. This form will be used to determine if the patient is able to utilize public transportation based on the patient's abilities and limitations.

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

PHYSICAL ABILITIES AND EQUIPMENT								
Can patient ambulate independently?	Does patient use any of the following assistive devices?							
☐ Yes. (Max. Distance:) ☐ No	☐ Walker	☐ Crutches	☐ Cane	☐ Portable Oxygen	☐ Service Animal	☐ 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 providers office.

If you have any questions, please call Alivi at (786) 441-8500