November 18, 2016

Dear Potential Martin County Client:

Thank you for your interest in becoming an MTM Client. We welcome the chance to meet your transit needs and offer you excellent customer service.

Included in this envelope you will find the Beneficiary Intake Form (BIF) and Level of Need (LON) Form. You should fill out the BIF and provide proof of income. Your doctor should complete the LON Form. Please return all documents to our Care Management Department.

Mailing Address

MTM
Attention: Care Management
16 Hawk Ridge Drive Lake St. Louis, Mo
63367

Fax Number

1-877-406-0658

The Beneficiary Intake Form, Level of Need Form and proof of income is required to be eligible for transportation. Please allow up to ten business days for MTM to receive and process your request. We look forward to helping you access your community. Again, we appreciate your interest. Thank you for fully completing the forms.

You will be informed of either an approval or denial of your application via phone within 10 business days.

Sincerely,

MTM's Care Management Department
CM-MartinCo@mtm-inc.net

Martin County Florida
Beneficiary Intake Form

Important Note: Please be sure to answer all questions. Failure to do so may result in your transportation benefits being denied. If you do not know the answer, please write "do not know". If a question does not apply, please write "N/A".

Please note: additional documentation may be required.

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Gender: ☐ Female ☐ Male

SSN: _____ Medicaid #: _____

Address: _____ City: _____

Zip: _____ County: _____

Phone #: _____ TDD Number: _____

Emergency Contact: _____ Relation: _____

Phone #: _____

Do you drive? ☐ Yes ☐ No

Do you own a car: ☐ Yes ☐ No

Do you have access to a working vehicle? ☐ Yes ☐ No

If yes, would you be interested in the mileage reimbursement program? ☐ Yes ☐ No

If provided access to a working vehicle, could you transport yourself? ☐ Yes ☐ No

Do you have any of the following that can provide you with transportation?

Family: ☐ Yes ☐ No Friend: ☐ Yes ☐ No

Volunteer: ☐ Yes ☐ No Other: _____

Are you a veteran? ☐ Yes ☐ No Number of people in your household: _____

Annual household income: _____ Source: _____(proof of income required)

Do you have the ability to pay a $1.00 co-pay each way for transportation? ☐ Yes ☐ No

Are you frail, disabled, or do you have some other physical or mental limitations? ☐ Yes ☐ No

How do you get to the grocery store? ☐ Drive Self ☐ Friend/Family ☐ Taxi ☐ Walk ☐ Bus/Public Transportation

Do you live within ¾ mile from a bus stop? ☐ Yes ☐ No ☐ I do not know

Is there any reason you cannot walk to your appointment? ☐ Yes ☐ No

If yes, please explain: _____

Martin County Florida
Beneficiary Intake Form

Do you live in a facility that provides transportation? ☐ Yes ☐ No

If yes, could they transport you to medical appointments? ☐ Yes ☐ No ☐ I do not know

Is there any reason you cannot take public transportation to your medical appointments? ☐ Yes ☐ No

Are you enrolled in any other programs that will pay for or provide transportation? ☐ Yes ☐ No

If yes, please explain: _____

Please check or list any special needs or services you require during transportation

☐ Powered Wheelchair ☐ Manual Wheelchair ☐ Walker/Cane ☐ Stretcher
☐ Portable Oxygen ☐ Service Animal ☐ Scooter ☐ Personal Care Attendant
☐ Other: _____

I understand and affirm that the information provided in this application for Non-Emergency Transportation (NET) to TD services is true and correct, to the best of my knowledge, and will be kept confidential and shared only with services and appointments. I understand providing false and/or misleading information, making fraudulent claims and making false statements constitutes a felony under the laws or the state of Florida.

Beneficiary Signature: _____ Date: _____

MTM USE ONLY

☐ Approved ☐ Denied

Date: _____ Signature: _____

16 Hawk Ridge Drive | Lake Saint Louis, MO 63367 | phone 636.561.5686 | fax 636.561.2962 | www.mtm-inc.net

L.O.N.

Martin County Level of Need Assessment

Facility Fax:

Dear Medical Professional:

Our office has received a request for transportation: please fill the Level of Need assessment form out in its entirety. This form will be used to determine the Beneficiary's most appropriate mode of transportation based on their functional abilities and limitations. Please provide any information that will assist us in identifying the mode of transportation that best fits the Beneficiary's needs.

Beneficiary Info	First Name:	Last Name:	Date of Birth:	
	Medicaid #:	Trip Number #:	Plan ID:	
	Address:	City:	State:	Zip:
Diagnosis Info	Diagnosis (MUST PROVIDE):		Diagnosis is: ☐ Permanent ☐ Temporary Through (date):	
	Recent Hospitalizations/Surgeries (MUST PROVIDE):			
Living Arrange-ments	☐ Lives alone or with family/friends ☐ Nursing facility ☐ Group home ☐ Residential rehab facility Comments:			
	Number of steps: _____ **NOTE**: MTM is unable to transport individuals requiring assistance up or down more than three (3) stair-steps from door to curb.			
Physical Abilities and Equipment	Can patient ambulate independently?	☐ Yes. (Max. Distance:_____)	☐ No	
	Does patient use any of the following assistive devices? ☐ Crutches ☐ Walker ☐ Cane ☐ Electronic Wheelchair ☐ Manual Wheelchair Can patient self-propel ☐ Yes ☐ No			
	Can patient self-transfer into vehicle? ☐ Yes ☐ No			
	Does patient use/require portable oxygen? ☐ Yes ☐ No			
	Does patient require a change in mode of transport due to instability?	☐ Yes (please explain):	☐ No	
	Has there been a decline in functionality?	☐ Yes (please explain):	☐ No	
Cognitive Abilities	What is the patient's cognitive ability? ☐ Alert and oriented (i.e. place, time) ☐ Alert and mildly confused (i.e. place, time) ☐ Confused (i.e. dementia, alzheimers) Comments:			
	Able to remove self from unsafe situation?	☐ Yes	☐ No	
Sensory Abilities	Vision	☐ Normal Vision ☐ Wearing glasses/ contacts ☐ Cataracts ☐ Legally Blind ☐ Service animal due to blindness Comments:		
	Speech & Hearing	☐ Normal hearing ☐ Wears hearing aid ☐ Deaf ☐ Speech Impairment Comments:		

Physician Info	Printed Name:	Phone #:
	Signature:	NPI #:

Questions? Please call the Care Management Department at 1-888-561-8747

Please fax this completed form to: **1-877-406-0658, ATTN: Care Management**

This form must be received no less than 72 hours prior to the appointment time or transportation cannot be arranged.