Level of Need (LON) Assessment Form Instructions

MTM has two LON assessment forms: the Standard LON Form and the Ambulance/Stretcher LON Form. ***LON Forms must be completed by a medical professional who is currently treating the member.***

The **Standard LON Form** is for both cab (ambulatory) and wheelchair (para lift) modes.

- This LON must be filled out for cab/ambulatory services if a member is within 3/4 mile of bus stop but needs a higher mode of transportation due to medical restrictions or needs. Exclusions include:
    - A member who is more than six months pregnant
    - Short notice or urgent trips
    - A member who is traveling to dialysis, chemotherapy, or radiation
    - A member who is further than 3/4 mile from a bus stop for the pick-up and drop-off addresses
    - A member who already has a LON on file for a higher mode of transportation

The **Ambulance/Stretcher LON Form** applies when a member needs a higher mode of transportation, including stretcher, Basic Life Support (BLS), or Advanced Life Support (ALS). This LON form must also be filled out if a member uses a wheelchair or mobility aid that requires the use of a para lift vehicle.

L.O.N.

Level of Need Assessment Form

Facility Fax:

Dear Medical Professional:

Our office has received a request for transportation for one of your patients. Please fill out this Level of Need Assessment form completely and provide any supporting information as needed. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations.

Patient Info	First Name:	Last Name:	Date of Birth:	
	Medicaid #:	Phone #:	Trip #:	
	Address:	City:	State:	Zip:
Diagnosis and Transport Info	Diagnosis that supports transportation limitations (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 at residence: _____			
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. 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)	Additional comments:		
	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:		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.