Harford County Health Department

Medical Assistance Transportation Grant Program
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Public Health
Prevent. Promote. Protect.
Harford County Health Department

MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORTATION TRANSFER/DISCHARGE FORM

SECTION 1 - PATIENT PERSONAL INFORMATION:

Last Name:	First Name:	Height:	Weight:	DOB:
Address:	City/State/Zip:			
Bldg or Facility Name: / Room Bed #	Patient Contact/Phone:			
Medical Assistance #:	Social Security # (Optional):	Medicare #:	Other Insurance:	

Is this recipient staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ Yes No ☐
(If Yes, Limited Transportation Benefits May Be Available To These Recipients. Please Contact Your Local Health Department MA Transportation Unit)

SECTION 2 –*FACILITY DISCHARGES and TRANSFERS INFORMATION:*

Pick-Up Information		Destination Information	
Facility		Facility	
Address	Zip Code	Address	Zip Code
Room/Suite/Floor		Room/Suite/Floor	
Sending Facility Contact Person	Name:	Phone:	Fax:
Date & Time Requested: Date:	Time:	Authorization #:	

SECTION 3 - MEDICAL DIAGNOSIS and CONDITION List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this participant that requires the recipient to be transported in ambulance, wheelchair or Metro rail/bus/sedan and why transport by other means is contraindicated by the participant's condition:

Underlying Medical Diagnosis (DO NOT Enter ICD or DSM Codes)	Medical Condition (Symptoms)

SECTION 4 – CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION

a) ☐ **AMBULATORY/ABLE TO WALK (with mobility aides)**: Enter distance of ambulation in feet:_____
Client may be transported by: ☐ Paratransit vehicle ☐ Public transit system ☐ Cab/Sedan

b) ☐ **WHEELCHAIR Check Type:** ☐ **REGULAR W/C** ☐ **ELEC. W/C** ☐ **ELECTRIC SCOOTER** ☐ **X-WIDE W/C** ☐ **SPECIALTY W/C**
Please check environmental conditions that are applicable: _____ **RAMP,** _____ **STEPS** If steps, give # _____ **OTHER** _____

c) ☐ **AMBULANCE - Check Appropriate Level (justify below if other than BLS)** ☐ **BLS** ☐ **ALS** ☐ **SCT/P** ☐ **SCT/N** ☐ **NEO-NATAL**

Clinical Interventions Necessitating Ambulance:_____

Please check building access that is applicable: _____ **RAMP,** _____ **STEPS** If steps, give # _____ **OTHER** _____

All of the following questions must be answered for this form to be valid:
1) Can this patient safely be transported by sedan or wheelchair van (that is, seated and secured during transport)? ☐ Yes ☐ No
2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No

To be "bed confined" all three of the following conditions MUST be met: (A) The recipient is *unable* to get up from bed without assistance; AND (B) The recipient is *unable* to ambulate; AND (C) The recipient is *unable* to sit in a chair or wheelchair. ☐ Hospital discharge of wheelchair patient – w/c not sent with patient

3) If not bed confined, reason(s) ambulance service is needed (check all that apply):

☐ Requires continuous O2 monitoring. (see instructions)
☐ Orthopedic Device – Describe:_____
☐ IV Fluids/Meds Required-Med:_____
☐ Cardiac/hemodynamic monitoring required during transport
☐ Decubitus ulcers – Stage & Location:_____
☐ DVT requires elevation of lower extremities
☐ Restraints (physical/chemical) anticipated/used during transport
☐ Bariatric Stretcher Please Explain:_____
☐ Ventilator dependent
☐ Requires airway monitoring/suctioning
☐ Contractures
☐ Other -Describe:_____

PSYCH TRANSFERS (if applicable): Circle one →(Voluntary) or (Involuntary): Sedated; [Y] [N] Restrained; [Y] [N] Combative; [Y] [N] Other_____

SECTION 5 - PROVIDER CERTIFICATION: To be FULLY completed by the classifications listed below.

By signing this form, you are certifying:
1. The services described are medically necessary AND
2. You understand that information provided is subject to investigation and verification. Misrepresentation or falsification of essential information which leads to inappropriate payment may lead to sanctions and/or penalties under applicable Federal and/or State law.

Check **Signee** Type: ☐ PHYSICIAN ☐ PA ☐ CRNP ☐ DISCHARGE NURSE ☐ SOCIAL WORKER		
Signature of **Signee**:	Date Signed:	Treating Provider/Facility Medical Assistance or NPI Number:
Printed Name of **Signee**:	Telephone #:	Printed Full Address of **Signee**: