MEDICAID HOME AND COMMUNITY- BASED WAIVER
ADULT DAY HEALTH CARE
MODE OF TRANSPORTATION

TO BE COMPLETED BY ADULT DAY HEALTH CARE AND MAINTAINED IN PARTICIPANT RECORD

PARTICIPANT NAME ________________________________
MEDICAID NUMBER______________________________

TRANSPORTATION TO BE PROVIDED BY:

_____ Participant’s residence within 15 miles; center responsible for transportation

_____ Participant’s residence within 15 miles; participant chooses to have responsible party, family or friend provide transportation

_____ Participant’s residence exceeds 15 miles; describe mode of transportation

______________________________________________________________________________
______________________________________________________________________________

I certify that the information above reflects the current transportation arrangements for this participant.

_____________________________   __________________________   ________________
Signature                                               Title                                            Date

USE SECTION BELOW TO DOCUMENT ANY CHANGES IN TRANSPORTATION ARRANGEMENTS.

TRANSPORTATION TO BE PROVIDED BY:

_____ Participant’s residence within 15 miles; center responsible for transportation

_____ Participant’s residence within 15 miles; participant chooses to have responsible party, family or friend provide transportation

_____ Participant’s residence exceeds 15 miles; describe mode of transportation

______________________________________________________________________________
______________________________________________________________________________

I certify that the information above reflects the current transportation arrangements for this participant.

_____________________________   __________________________   ________________
Signature                                               Title                                            Date