

**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

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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.**

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