LANDOFSKY TRANSPORTATION RESOURCE CENTER
A PROGRAM OF LAND OF SKY REGIONAL COUNCIL

Date:

Dear:

Non-Emergency Medicaid Transportation
339 New Leicester Hwy., Suite 140
Asheville, NC 28806
p: 828.552.5486 | f: 828.552.4234
w: landofsky.org

Please read the following and fill out all forms in their entirety.

If I do not hear from you by _____, which is 14 days from the date of this letter, I'll assume you no longer need Medicaid Transportation services, and your case will be closed.

- These services are for **Medicaid**-billable appointments only.
- We require **3 Business days** for trips within Buncombe County and 5 Business days for out-of-county trips. (You must call your caseworker in advance to make sure required DHB-5048 forms are in place.)
- Beneficiaries are responsible for getting the **DHB-5118 verification** signed at each appointment. If you are driving yourself, you will submit it with your request otherwise you need to return it to the driver at pick-up.
- **Cancellations** must be called at least **2-hours** before your scheduled pick-up time to avoid getting a no-show. (Earlier appointments need to be cancelled the day prior.)

A COPY OF THE FULL "**GENERAL INFORMATION AND GUIDELINES**" HAS BEEN ENCLOSED ALONG WITH THE "**THE NOTICE OF RIGHTS & RESPONSIBILITIES**" (DHB-5046) FOR YOU TO READ AND KEEP.

If you have any questions about these guidelines, please contact me at the phone 828-552-5486.

I have read and understand the "General Information and Guidelines" for the Buncombe County Medicaid Transportation Program. I agree to abide by all rules and regulations listed in these guidelines. Once I am approved for Medicaid Transportation Services, I will contact my transportation worker if any change occurs in my home. These changes could be, but are not limited to, change of address, change in telephone number, or change in physician or medical provider.

_____ _____

Client Signature Date

COMPLETE THIS FORM ENTIRELY

Name: _____ **Phone Number**: ( ) _____ -_____
Social Security #:_____-_____-_____ **Date of Birth**: _____
Mailing Address:_____
City/State_____ Zip:_____
Home Address:_____
City/State_____ Zip:_____
Emergency Contact Name:_____
Relationship: _____Phone Number ( ) _____ -_____

1. Do you have access to a vehicle that can be used to get to and from your medical appointments?
   ☐ Yes ☐ No ☐ Sometimes (Explain)_____
2. How have you been getting to your medical appointments? (Check all that apply)
   ☐ Drive Yourself ☐ Friend/Relative provides transport ☐ Bus/Taxi
   ☐ Transportation services from an agency such as DSS, Health Department, Council on Aging, etc.
   Name of Agency: _____
3. Do you live within walking distance of a bus stop? ☐ Yes ☐ No
   If yes, how many blocks would you have to walk to get to the nearest bus stop? _____Blocks
   If yes, do you have a health condition that would prevent you from riding the bus?
   _____
4. Is there a reason why the source you have been using can no longer transport you to your medical appointments?
   ☐ Yes ☐ No If yes, explain: _____
5. How long are these circumstances expected to continue: _____
   Special Transportation Needs: (Check any of these items you use while traveling)
6. Is it medically necessary for an attendant to travel with you: ☐ Yes ☐ No
   Name of Attendant: _____
   ☐ Wheelchair (type ☐ motorized ☐ manual) Do you have a ramp? ☐ Yes ☐ No
   ☐ Cane ☐ Walker ☐ Crutches ☐ Scooter
   ☐ Compact Portable Oxygen Tank ☐ Respirator ☐ Service Animal
   ☐ Accompanying Adult for Minor Child Name: _____
   ☐ Child Car Seat (type) _____
   Accompanying Translator ☐ Yes ☐ No Translator Name: _____
   Do you have trouble with: ☐ Disorientation ☐ Hearing ☐ Sight ☐ Speech ☐ Other _____

7. In order for you to receive Medical Transportation, we need you to list AT LEAST ONE doctor or medical provider you use. (Please note: If there are no providers listed, transportation may be denied.)

_____

_____

_____ _____
Signature Date

Any information on this form will remain confidential

Revision Date 8/14/24