Long-Distance Transportation
Patient Eligibility Questionnaire For Up-Front Expense Assistance

Patient Information

Patient Name:_____
Last First Middle Initial

Account Number:_____ Admission/Treatment Start Date:_____

Address:_____

City/State/Zip:_____

Date of Birth: _____/_____/_____

Primary Phone #:_____ □ Home □ Mobile □ Work □ Other:_____

Prior Patient Here: □ Yes □ No Patient Rec'd Behavioral Treatment in last 36 months: □ Yes □ No

Patient Eligibility Screening Questions

1. Did the patient, family member or representative express a need for transportation assistance? □ Yes □ No
   - If someone other than the patient, family member, or representative expressed the need, then please identify and explain:_____
2. Is the patient (or person financially responsible for the patient) currently employed on a full-time basis?
   □ Yes □ No
3. Does the patient have the current financial ability to pay for transportation in order to receive treatment?
   □ Yes □ No
4. Are other treatment providers with same or similar services available within 25 miles of the patient (75 miles if the patient is in a rural location)?
   □ Yes □ No □ Unknown
   - If No, then proceed to #5.
   - If Yes, is the patient able to access the closer options? □ Yes □ No □ Unknown
     - If Yes/Unknown, has the patient's treatment team determined it is in the patient's best interest to seek treatment from this Facility over local options?
       □ Yes □ No □ Unknown
     - If No/Unknown directly above, then stop analysis. Patient is not eligible for assistance if the patient elects on his/her own to bypass local treatment options equivalent to that of Facility unless the patient's treatment team advises that treatment at this Facility is in the patient's best interest.
5. Please identify any other clinical, socioeconomic, mobility, geographic, or other circumstances experienced by the patient that are long-distance transportation barriers to the patient accessing care (attach sheet if necessary):_____

6. Is the patient able to travel safely without assistance by non-emergency ground vehicle, bus, or rail?
   □ Yes □ No
   - If No, then proceed to #7.
   - If Yes, then please describe the basis for this determination:_____

7. If No to #6, then identify the special transportation arrangements needed by the patient to travel safely (e.g. ambulance, air, sitter)?
   - Please specify assistance needed (check all that apply): □ Ambulance □ Air □ Sitter
     □ Other (specify):_____
     - Was the request made by patient's current treating provider? □ Yes □ No
     - Please describe the basis for determination that patient needs special transportation arrangements, including recommendation for a sitter, and list clinical indications (attach sheet if necessary):_____
   - If the patient needs air transportation, is the patient able to travel safely without a sitter?
     □ Yes □ No
     - Please describe the basis for this determination:_____
   - If a sitter is advisable, then does the sitter also need transportation assistance to or from a Facility location? □ Yes □ No
     - If Yes, then please describe the basis for determination that the sitter also needs transportation assistance:_____

By my signing below, I certify that everything stated on this form is true to the best of my knowledge based on information received from the patient or third parties knowledgeable about the patient's circumstances.

Signature:_____ Date:_____

Print Name:_____ Facility Title:_____