LogistiCare

LGTC USE ONLY
Date Received:_____

ATTENDANT CARE ELIGIBILITY ASSESSMENT

REQUESTOR: Please complete this form providing a clear explanation for each of your responses and attach any documentation that will help us to evaluate your request fairly. Fax the request to **ATTN: Utilization Department (866) 907-1491** or mail to **Utilization Department**, PO Box 248, Norton, VA 24273. Thank you.

1. Requestor _____ Title_____ Agency _____
2. Phone _____ E-mail _____@_____
3. Mailing Address _____

			A written explanation is **required** for each question.
1	What options have been explored to transport client safely?		
2	List any self-injurious behaviors?		
3	Does the client act aggressively towards other individuals? If yes, please explain.		
4	List any destructive behaviors? (Example: Disassembles or breaks things)		
5	List client's inappropriate behaviors in public? If any.		

Client Name:_____ **Medicaid ID:_____** **Date_____**

6	In Reference to questions 2 – 5 list any triggers or forewarning for the above mentioned behaviors?		
7	How are the client's behavioral outbursts managed? (Example: IPOD, Book, Radio, etc.)		
8	Please list any recent incidents that have taken place during transport? Please provide a brief explanation of the incident along with the date it took place. Was an incident report filed with LogistiCare?		
9	On a scale of 1 to 10 Please rate the client's behavioral outbursts? (1 – Not a serious problem; 10 Extremely Serious/Critical) How often does the client have behavioral issues?		
10	How does the client communicate his/her needs?		
11	Additional Comments: Please provide any information you feel will assist us in evaluating your request.		

Client Name:_____ Medicaid ID:_____ Date_____

Requestor's Signature: _____ Title _____ Date_____

LogistiCare Recommendation ☐ **Attendant** ☐ **No Attendant**

Reviewed by Signature: _____ Title _____ Date_____

DMAS Final Action ☐ **Attendant** ☐ **No Attendant**

Reviewed by Signature: _____ Title _____ Date_____

Reviewer Notes:

Client Name:_____ Medicaid ID:_____ Date_____