L.O.N.

Level of Need Assessment Form

Facility Fax:

Dear Medical Professional:

Our office has received a request for non-emergency medical transportation for a Wisconsin Medicaid or BadgerCare Plus member. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations. **Please fill out this Level of Need Assessment (LON) form completely and provide any supporting information as needed.**

Patient Info	First Name:	Last Name:	Date of Birth:	
	ForwardHealth ID #:	Phone #:	Trip #:	
	Address:	City:	State:	Zip:
Living Arrange-ments	☐ Lives alone or with family/friends ☐ Group home ☐ Residential rehab facility Comments:			
	Number of external steps at residence: _____			
Physical Abilities and Equipment	Can patient ambulate independently? ☐ Yes. ☐ No			
	Does patient use any of the following assistive devices? ☐ Cane ☐ Crutches ☐ Walker ☐ Portable Oxygen ☐ Service Animal ☐ Electric Wheelchair ☐ Manual Wheelchair			
	Does patient require assistance of trained personnel for safety? ☐ Yes ☐ No			
	Can patient self propel in wheelchair? ☐ Yes ☐ No	Can patient self-transfer from wheelchair? ☐ Yes ☐ No		
	Do environmental factors like heat or cold affect the patient's mobility? ☐ Yes (please explain): ☐ No			
	Has there been a decline in functionality? ☐ Yes (please explain): ☐ No			
Cognitive Abilities	Does the patient have problems with any of the following? If yes, circle a rating for each category, with 1 being mild impairment and 5 being severe impairment. Alertness ☐ No ☐ Yes 1 2 3 4 5 Memory Issues ☐ No ☐ Yes 1 2 3 4 5 Confusion ☐ No ☐ Yes 1 2 3 4 5	Additional comments:		
	Able to remove self from unsafe situation?	☐ Yes	☐ No	
Sensory Abilities	Vision	☐ Cataracts ☐ Legally blind Comments:		
	Speech & Hearing	Deaf? ☐ Yes ☐ No	Able to communicate needs? ☐ Yes ☐ No	
Diagnosis and Transport Info	Diagnosis that supports transportation limitations (MUST PROVIDE, if applicable):		Diagnosis is: ☐ Permanent ☐ Temporary Through (date):	
	Recent Hospitalizations/Surgeries (MUST PROVIDE):			
Medical Professional Info	Printed name and credentials:		Phone #:	
	Signature:		NPI #:	

Questions? Please call the Care Management Department at 1-866-831-4130

Please fax this completed form to: **1-866-686-7618, ATTN: Care Management**

This form must be received no less than two business days prior to the appointment to ensure the appropriate mode of transportation.