**AGED AND DISABLED WAIVER- PRIOR AUTHORIZATION REQUEST FOR TRANSPORTATION**

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| **Date of Request** | | **Provider Agency Name** | |
| **Person's Name and Medicaid Number** | | **Contact Name and Phone** | |

**Description of Utilization of Transportation Services:** Provide documentation about the past month regarding mileage. Be specific – where did the PA travel to? What was the purpose? Was there something closer that could have provided the need? If so, why was it discarded to go someplace farther away?

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**Documentation:** Provide documentation about what the anticipated mileage will be for the month that you will exceed 300 miles. Provide proof if this is going to be a reoccurring appointment.

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**Alternative Resources:** Provide information about what efforts were made to use other sources for transportation such as friends, family, senior center transportation, etc.

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**Location:** Description of where person lives, where the closest grocer is, affordability of the items at that grocer, location of closest quick mart, etc.

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**Attach the Person Centered Assessment, Service Plan and one month of daily documentation.*

Signature: _____ Date: _____