CCT PL#16-011
Attachment 2

Last Rev: 02-19-16

CCT-Required Non-Emergency Medical Transportation Information

Section 1. General Information

1. CCT Lead Organization (LO)	
2. Form completed by	3. CCT LO's Program Director
4. Patient's name	5. Medi-Cal I.D. number
6. Does this individual have an approved *Initial Transition and Care Plan* and 100-hour TAR? **Yes** **No** – If not, do not proceed until both are approved	
7. CCT-related pre-transition purpose/justification for trip: _____ _____ _____	
8. Mode of Transportation: **Medical** (ambulance or wheelchair / litter van) - complete Sections 2 & 4, and skip Section 3 **Non-medical** (public transit or private vehicle) - complete Section 3 & 4, skip Section 2	
9. Provider: Commercial Company Public Transit Private Transportation	10. Trip: One-way Round Trip Date(s) _____ Distance _____ (in miles)

Section 2. Non-emergency Medical Transportation (**NEMT**) - Skip this section if **non-medical** transportation was used

11. If commercial NEMT is used, provide the **Name of Company**:

_____

Company's **Phone Number** _____

12. Indicate the reason(s)/diagnosis necessitating medical transportation: _____

_____

_____

_____

13. Total cost of service $_____ Form of payment _____

Important Note: Do not bill CCT for NEMT services allowable under California Code of Regulations [CCR], Title 22, Section 51323.[1]

[1] http://files.medi-cal.ca.govpublications/masters-mtp/part2/mctrangnd_a05.doc

CCT-Required Non-Emergency Medical Transportation Information

Section 3. **Non**-medical Transportation - Skip this section if **medical** transportation was used

14. Driver's Name _____

    Driver's License State _____ Lic. Number _____

    Driver's Address _____ City _____ Zip _____

    Telephone Number (___) ___ - ____ Ext. (_____)

    Relationship to Patient _____

15. **PRIVATE** Transportation:

    *Effective January 1, 2016, the personal vehicle mileage reimbursement rate will be **54 cents per mile**. The current and future reimbursement rate is directly tied to the Internal Revenue Service's published mileage reimbursement rate.*

    Total Mileage (as defined in PL 16-011)**:** _____ **x $0.54 cents/mile**

    = Total Reimbursement Amount: $ _____

    Note: A copy of the driver's valid state driver's license, car registration, and insurance coverage must be attached to each TAR for private transportation.

16. **PUBLIC** Transportation:

    Itemized Costs - please attach a separate sheet of paper to itemize additional costs, if necessary

Description	Cost	Description	Cost
_____	$ _____	_____	$ _____
_____	$ _____	_____	$ _____
_____	$ _____	_____	$ _____
_____	$ _____	_____	$ _____

Total Cost. $ _____

Section 4. Signatures

17. By signing below I, _____, attest that all of the information included in this form is accurate and allowable per CCT PL# 16-011; and, that supporting documentation is available for all CCT-related pre-transition transportation costs. I understand that my organization must adhere to documentation retention requirements within Exhibit B, Provision 2: Expense Allowability / Fiscal Documentation and Exhibit D(F), Special Terms and Conditions of the CCT Lead Organization Contract; specifically, Exhibit B, Provision 2, subparagraphs B. and C.

_____ _____

Signature Date

_____ _____

CCT LO's Program Director's Signature Date