Individual Transportation Services Protocol Checklist

Service Recipient's Name _____ **Date of Birth** _____
(Last, First)

Reviewer's Name _____ **Date Request Submitted** _____
(Last, First)

Technical Review

☐ **YES** ☐ **NO**	Is the correct funding source, site code, and service code used in Section C of the Individual Support Plan? If **YES**, continue to Question #1. If **NO** and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1. If **NO** based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the waivers and in the TennCare rules applicable to the waivers.

A. Individual Transportation

1. ☐ **YES** ☐ **NO**	Does the service recipient have family members, natural supports, or public transportation to provide needed transportation without charge? (A. 1.) If **YES**, **deny** as **non-covered service** based on waiver services definition. If **NO,** proceed to Question #2**.**
2. ☐ **YES** ☐ **NO**	Is transportation being requested for one of the following reasons which are specifically excluded in the waiver service definition: (A. 2.a) a. Transportation to and from Day Services; **OR** (A. 2. a.) b. Transportation to and from supported or competitive employment; **OR** (A. 2. b.) c. Transportation of school-age children to and from school; **OR** (A. 2. c.) d. Transportation to and from medical services covered by the Medicaid State Plan/TennCare **OR** (A. 2. d.) e. Transportation of a service recipient receiving residential services (Supported Living, Residential Habilitation, Family Model Residential Support, or Medical Residential Services) for which the provider is responsible for providing transportation (excluding Orientation and Mobility Training and Behavioral Respite Services)? (A.2.e) If **YES**, **deny** as **a non- covered service** based on waiver services definition. If **NO,** proceed to Question #3.

3. ☐ **YES** ☐ **NO**	Is there sufficient information regarding need to access activities in the ISP, to document that Individual Transportation services are needed for the service recipient to access approved activities specified in the ISP, excluding items specified in "2a" through "2e" above? (A. 3.) If **YES**, proceed to Question #4. If **NO**, **<u>deny as not medically necessary</u>**.
4. ☐ **YES** ☐ **NO**	Is the amount requested consistent with and not in excess of amount needed to access approved activities specified in the Individual Support Plan, excluding items specified in "2a" through "2e" above? (A. 4.) If **YES**, approve the amount requested. (NOTE: Cannot exceed the monthly maximum of 31 units or the maximum of 365 units per program year). If **NO**, approve that portion of the total amount requested that is *consistent with* the amount needed to access approved activities specified in the Individual Support Plan. **<u>Deny</u>** as **<u>not medically necessary</u>** that portion of the total amount requested that is *in excess of* the amount needed to access approved activities specified in the Individual Support Plan, excluding items specified in "2.a" through "2.e" above.
☐ **Approved**	
☐ **Denied**	Criteria_____ not met.