PROVIDER*Update*

REGULATORY | NOVEMBER 30, 2022 | UPDATE 22-973 | 11 PAGES

Action Required for NEMT Requests for Medi-Cal Patients

A signed Physician Certification Statement form is required for NEMT. Refer to the attached form.

California Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008, *Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*, outlines updated requirements for providing transportation for Medi-Cal members, as well as for travel expenses.

Non-emergency medical transportation (NEMT)

NEMT services are a covered Medi-Cal benefit when they are prescribed in writing by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender, for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx. A physician extender includes non-physician medical practitioners, which includes physician assistants, nurse practitioners and certified midwives.[1]

California Health & Wellness Plan (the Plan) is required to provide medically necessary NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services.

For NEMT, keep in mind:

- **The DHCS requires that a physician or other provider must complete a Physician Certification Statement (PCS) form** authorizing NEMT for the member. The member's physician or other provider must submit the PCS form to the Plan's transportation vendor (Modivcare) for the provision of NEMT services. Once the member's treating provider prescribes the form of transportation, the Plan cannot modify the authorization. **If a PCS form is not received, members will not receive the necessary transportation.**

Discover Helpful Tools to Support Your Office

Go to **cahealthwellness.com/providers** to quickly access information to help you in your everyday interactions with California Health & Wellness Plan. The site includes:

- The Provider manual
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THIS UPDATE APPLIES TO:

- Physicians
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- Community Supports (CS) Providers
- Enhanced Care Management (ECM) Providers

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8 a.m. to 5 p.m. (PT)

Fax Numbers

Prior Authorizations: 866-724-5057
Concurrent Review: 855-556-7910
Admissions: 855-556-7907
Appeals: 855-460-1009
Case Management: 855-556-7909

Pharmacy

Medi-Cal Rx – Self-administered drugs and supplies obtained under the pharmacy benefit

- Prior auth fax: 800-869-4325
- Help Desk: 800-977-2273

AcariaHealth – Specialty Pharmacy

- Prior auth fax: 855-217-0926
- Phone: 855-535-1815

CHWP Pharmacy Dept – Provider-administered drugs requiring prior auth

- Prior auth fax: 877-259-6961
- Phone: 877-658-0305

Medication Prior Authorization Form is available at www.CAHealthWellness.com.

- The Plan must use the PCS form to provide the appropriate mode of NEMT for members. The Plan must have a process in place to share the PCS form or communicate the approved mode of NEMT and dates of service to the NEMT broker or provider for the arrangement of NEMT services. [1]
- The Plan must ensure that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the physician or other provider. Also, the Plan must have a mechanism to capture and submit data from the PCS form to DHCS.
- Members must be able to request a PCS form from their physician or other provider by phone, electronically, in person or by another method established by the Plan.
- The Plan must use an NEMT PCS form that has been approved by DHCS and includes the required components to arrange for NEMT services for its members. If a Plan makes any changes to the PCS form since the last approval received from DHCS, the Plan must resubmit for approval.

- **For recurring appointments**, the PCS form can authorize NEMT for the duration of the recurring appointments, not to exceed 12 months.[1]
- **For pharmacy services**, the Plan must provide medically appropriate NEMT services for members for to obtain pharmacy prescriptions prescribed by the member's Medi-Cal providers and those authorized under Medi-Cal Rx.[1]
- **Exceptions:** A PCS form is not needed for NEMT if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.[1]

  The Plan can provide phone authorization for NEMT requests when a member requires a covered medically necessary service of an urgent nature and a PCS form could not have reasonably been submitted beforehand. The member's provider must submit a PCS form post-service for the phone authorization to be valid.[1] When the Plan provides a phone authorization, the Plan's transportation vendor will initiate the process for collecting a PCS form. Once the first request is faxed to the rendering provider, the provider has 24 hours to return the form.

The Plan must ensure that a medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with the managed care plan contract. The Plan is also required to authorize, **at a minimum, the lowest cost type of NEMT** service (see APL 22-008 for information about modalities) that is adequate for the member's medical needs, as determined by the medical professional. Plans must ensure that there are no limits to receiving NEMT as long as the member's services are medically necessary, and the member has a PCS form for NEMT.

For Medi-Cal services that are not covered under the managed care plan contract, the Plan must make its best effort to refer and coordinate NEMT services. However, the Plan must provide medically appropriate NEMT services for all pharmacy prescriptions prescribed by the member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.[1]

Do not change or downgrade modality for NEMT

The Plan must ensure that it or its transportation broker provides the appropriate modality prescribed by the member's physician or other provider in the PCS form. The Plan or its transportation brokers may not change the modality outlined in the PCS form, or downgrade members' level of transportation from NEMT to non-medical transportation (NMT). If a member's condition has changed and requires a different modality than originally indicated, a new PCS form is required, even if changing to NMT (ambulatory).

Scheduling and timely access for NEMT

The Plan must ensure that it meets timely access standards as set forth in 28 CCR section 1300.67.2.2. The member's need for NEMT services does not relieve the Plan from complying with timely access standard obligations. The Plan must note in their Member Services Guide the notification timeframe requirements for transportation requests and have a direct line to the Plan's transportation liaison for providers and members to call, request and schedule urgent

and non-urgent NEMT transportation and receive status updates on their NEMT rides. The liaison must ensure that authorizations are being processed during and after business hours.[1]

The Plan must inform its members that the member must arrive within 15 minutes of their scheduled appointment. If the NEMT provider is late or does not arrive at the scheduled pick-up time for the member, the Plan must authorize urgent NEMT to ensure the member does not miss their appointment.[1]

Services requiring NEMT within three hours

To ensure a timely transfer, NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility, must be provided within three hours of the member or provider's request. If NEMT services are not provided within the three-hour timeframe, the acute care hospital may arrange, and the Plan must cover, out-of-network NEMT services.[1]

The Plan must have a process in place to ensure their transportation brokers and providers are meeting these requirements and to impose corrective action on their transportation brokers if non-compliance is identified through oversight and monitoring activities.[1]

Non-medical transportation (NMT)

The Plan must provide NMT services necessary for members to obtain medically necessary Medi-Cal services, including those not covered under the managed care plan contract. Services that are not covered under the managed care plan contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal fee-for-service delivery system, **including pharmacy services provided to members upon the implementation of Medi-Cal Rx**.[1]

The Plan must take into consideration the member's abilities when scheduling the NMT service. The NMT service requested must be the least costly method of transportation that meets the member's needs.

The Plan is contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT services. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available. At a minimum, the following NMT services must be provided:

- Round-trip transportation for a member by passenger car, taxicab or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
- Round-trip NMT is available for:
  - Medically necessary covered services.
  - Members picking up drug prescriptions that cannot be mailed directly to the member.
  - Members picking up medical supplies, prosthetics, orthotics and other equipment.

Scheduling and timely access for NMT

NMT must be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

The Plan must inform its members that they must arrive within 15 minutes of their scheduled appointment. If the NMT provider does not arrive at the scheduled pick-up time, the Plan must provide alternate NMT or allow the member to schedule alternate out-of-network NMT and reimburse for the out-of-network NMT.

Conditions for NMT services

- The Plan may use processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian or spouse, to accompany the member in a vehicle or on public transportation, subject to approval at time of the initial NMT request.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the Plan in person, electronically or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  - Has no valid driver's license;
  - Has no working vehicle available in the household;
  - Is unable to travel or wait for medical or dental services alone; or
  - Has a physical, cognitive, mental or developmental limitation.

Authorization for NMT

The Plan requires prior approval for NMT services for each member prior to the member using NMT services. The Plan is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The Plan's prior approval process must be consistently applied to medical/surgical, mental health, and substance use disorder services as required by 42 CFR 438.900 Subpart K. All prior approval policies and procedures are subject to DHCS review and approval. NMT services are arranged and provided by contacting the Plan or the Plan's contracted transportation vendor. A PCS form is **not** required for NMT services.

Private vehicle authorization requirements for NMT

The Plan must authorize the use of private conveyance (passenger vehicle) when no other methods of transportation are reasonably available to the member or provided by the Plan. Private conveyance is transportation via a privately owned vehicle arranged by the member. This can include the member's personal vehicle, or that of a friend or family member. This does not include vehicles that are connected to businesses, such as Uber or Lyft.

The Plan must have policies and procedures to reimburse their members and are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation. The member cannot be the driver.

Updated requirements for NEMT and NMT for minors

Unless otherwise provided by law, the Plan must provide NEMT or NMT for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, The Plan may arrange NEMT or NMT services for a minor who is unaccompanied by a parent or a guardian. The Plan must provide transportation services for unaccompanied minors when applicable state or federal law does not require parental consent for the minor's service. The Plan is responsible to ensure all necessary written consent forms are collected prior to arranging transportation for an unaccompanied minor. The Plan may not arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless state or federal law does not require parental consent for minor's service.

Transportation brokers

The Plan may subcontract with transportation brokers for the provision of the NEMT or NMT services. Transportation brokers may also have their own network of NEMT or NMT providers to provide rides to members. However, the Plan must have the ability to supplement their transportation network if a transportation broker's network is not sufficient.

The Plan cannot delegate its obligations related to responsibility for monitoring and oversight of their network providers and subcontractors, grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions, including the review of PCS forms, to a transportation broker. The Plan may delegate its obligations related to grievances and appeals, enrollment of NEMT or NMT providers as Medi-Cal providers, or utilization management functions to a subcontractor, so long as the Plan does so in a written subcontract or agreement and comply with the requirements set forth in APL 17-004, APL 19-004, APL 21-011 and the managed care plan contract. A transportation broker cannot be delegated these Plan responsibilities by default because they have contracts with transportation providers and must meet all the subcontractor requirements to delegate the Plan's obligations mentioned above.

Additionally, transportation brokers cannot triage the member's need to assess for the most appropriate level of NEMT service and must arrange or provide the modality of transportation prescribed in the PCS Form. **Transportation brokers cannot downgrade the member's level of care from NEMT to NMT, including ambulatory door-to-door services.**

The Plan must require transportation brokers to have a process in place to identify specific NEMT or NMT providers, including the name of the drivers, based on service date, time, pick-up/drop-off location, and member name. The Plan must also have a process in place for members to be able to identify specific drivers in a grievance.

Related travel expenses for NEMT and NMT

The Plan is required to cover transportation-related travel expenses determined to be necessary for NEMT and NMT, including the cost of transportation and reasonably necessary expenses for meals and lodging for members receiving medically necessary covered services and their accompanying attendant. The Plan may reference the IRS per diem rates for lodging and meals as a guide. The salary of the accompanying attendant determined to be necessary is a covered travel expense as well if the attendant is not a family member, as set forth in 42 CFR section 440.170(a)(3)(iii). The Plan may utilize prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary. This does not preclude the Plan from requiring a PCS form for all NEMT authorizations. Transportation-related travel expenses are subject to retroactive reimbursement. To qualify for retroactive reimbursement of related travel expenses the underlying NEMT or NMT service and the related expenses must be appropriately documented in accordance with the MCP's policies and procedures.

Plans requiring prior authorization and utilization management controls for related travel expenses must notify their members of the process to request authorization. If a member fails to comply with a Plan's prior authorization process, the Plan is not required to cover the member's related travel expenses.

A member is eligible for coverage of related travel expenses including, but not limited to, circumstances where the member is obtaining a medically necessary service that is not available within a reasonable distance from a member's home, such that the member is unable to make the trip within a reasonable time.

Payment

The Plan is required to have procedures in place to provide the following methods of payment for related travel expenses:

- Member Reimbursement: The Plan can reimburse members for approved travel expenses. Reimbursement must cover the actual expenses incurred by the member and the accompanying attendant as long as those expenses are reasonable and supported by receipts. The Plan may reference the IRS per diem rates for meals and lodging as a guide. If the member or the member's family paid for travel expenses up front, the Plan must approve and reimburse the member or member's family no later than 60 calendar days following confirmation that all required receipts and documentation have been received by the Plan.
- Pre-payment to Vendor: The Plan must prepay vendors for related travel expenses, including expenses for meals and lodging, if the member and the accompanying attendant are unable to pay in advance. The member must attest to the Plan in person, electronically, or over the phone that they are unable to pay in advance for related travel expenses.

Lodging

If the Plan does not prepay for the member's and accompanying attendant's lodging, the Plan is required to provide reimbursement for approved lodging expenses. Reimbursement must cover actual expenses, as long as those expenses are reasonable and supported by receipts. the Plan may reference the IRS per diem rates for lodging as a guide. As part of the prior authorization process, the Plan may arrange lodging to be used by the member and accompanying attendant, so long as it is located within a reasonable distance from the location where the member will obtain medically necessary services.

Meals

If the Plan does not prepay for the member's and accompanying attendant's meals, the Plan is required to provide reimbursement for approved meal expenses. Reimbursement must cover the actual expenses, as long as those expenses are reasonable and supported by receipts. The Plan may reference the IRS per diem rates for meals as a guide. Hospital meal voucher(s) may be deducted from the meal expenses submitted by a member and accompanying attendant.

Other necessary expenses

If the Plan does not prepay for other necessary expenses (e.g., parking, tolls) incurred by the member and accompanying attendant, the Plan is required to provide reimbursement for other necessary expenses. Reimbursement must cover the actual expenses, as long as those expenses are reasonable and supported by receipts.

Enrollment of transportation providers

Plans that develop their own enrollment process must comply with the requirements set forth in APL 19-004 or any superseding APL. The Plan's enrollment process is subject to DHCS' review and approval prior to implementation.

All NEMT and NMT providers must comply with the enrollment requirements set forth in APL 19-004 or any superseding APL. Transportation network companies (TNC) providers such as Uber and Lyft are subject to the enrollment requirements outlined in APL 19-004 or any superseding APL. The Plan is not responsible for credentialing TNC NMT drivers. The Plan may have policies and procedures in place to authorize TNC NMT drivers, to provide NMT services to their members.

A Plan may allow NEMT and NMT providers to participate in its network for up to 120 days, pending the outcome of the enrollment process. However, a Plan must terminate its contract with a NEMT or NMT provider upon notification from DHCS that the provider has been denied enrollment in the Medi-Cal program, or upon expiration of the one 120-day period. The Plan must have a process in place to track the 120-day timeframe for contracted NEMT and NMT providers with pending applications to ensure the contracts do not exceed 120 days. If the NEMT or NMT providers are unable to successfully enroll in Medi-Cal, the Plan cannot continue to contract with the providers during the period in which the provider resubmits its enrollment application to DHCS or with the Plan. The Plan can only re-initiate a contract upon the provider's successful enrollment as a Medi-Cal provider. If the NEMT or NMT provider termination may impact member access, the Plan must notify DHCS and submit a plan of action for continuity of services for review and approval.

Transportation brokers are not required to be enrolled in the Medi-Cal program. However, the Plan must demonstrate that its transportation broker(s) are only conducting administrative activities such as scheduling rides. If the broker is providing rides to members (NEMT or NMT services), the broker must be enrolled as an NEMT or NMT provider.

Transportation for major organ transplants

The Plan must provide major organ transplant (MOT) donors NEMT or NMT transportation at the request of the MOT donor or the member who is the recipient. PCS forms are not required for MOT donors requesting NEMT services to ensure the donor has the ability to get to the hospital for the MOT transplant.

The Plan may utilize prior authorization and utilization management controls for the provision of related travel expenses, including protocols for determining whether an attendant is necessary for the member and the donor. The Plan must allow an attendant for the donor if the Plan determines that an attendant to accompany the donor is necessary.

The Plan must also cover travel expenses for MOT donors as described in the travel expenses section of this provider update.

Required forms

Please refer to the attached forms for use as needed:

1. PCS form
2. Consent for Minors to Travel Without an Escort

Get a PCS form on the provider website

Download the PCS form on the provider website at www.CAHealthWellness.com. Once on the website, go to *For Providers* > *Provider Resources* > *Manuals, Forms and Resources* > Forms.

Prior authorization requirements

The prior authorization list for California Health & Wellness Plan (CHWP) has been updated. Clarification has been added that states all NEMT requires a PCS form for:

- Air transportation (air ambulance), authorized by CHWP.
- Ground NEMT, contact Modivcare (ambulance, gurney/stretcher, wheelchair).

Other areas of the CHWP website that were updated include:

- Medi-Cal Pre-Auth at www.cahealthwellness.com/providers/preauth-check/medicaid-pre-auth.html. A bullet was added: “Non-emergency medical transportation (NEMT), submit the Physician Certification Statement (PCS) form to Modivcare.”
- Prior Authorization at www.cahealthwellness.com/providers/resources/prior-authorization.html. The Modivcare fax number was added.

Additional information

Relevant sections of the provider operations manuals have been revised to reflect the information contained in this update as applicable. The provider operations manual is available in the Provider Resources section of the provider website at www.CAHealthWellness.com.

Providers are encouraged to access CHWP’s provider portal online at www.CAHealthWellness.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact California Health & Wellness Plan at 877-658-0305.

[1] Information taken or derived from APL 22-008, *Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses*. dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf.

california health & wellness

Physician Certification Statement Form – Request For Transportation

THIS FORM MUST BE COMPLETED IN FULL AND SIGNED OR IT WILL NOT BE PROCESSED

The purpose of this form is for physicians to communicate to Modivcare™ specific transportation restrictions of a patient/member due to a **medical condition.** The restrictions and requirements stated on this form will be used by Modivcare to assign the best means of transportation for the patient/member.

THEREFORE, THE STATEMENTS MADE BY PHYSICIANS REGARDING PATIENT TRANSPORTATION RESTRICTIONS ARE MADE UNDER PENALTY OF MEDICAID FRAUD.

Patient name: ______________________________

Patient ID #/CIN #: ______________________ Patient DOB: ____/____/____

If the patient requires **NEMT**, **refer to page 2 to determine the medically necessary mode of transport.** Then, select one of the following:

☐ Gurney/litter/stretcher van ☐ BLS ambulance ☐ ALS ambulance ☐ Critical care transport
☐ Air transportation ☐ Wheelchair van

These services require physician justification and signature below.

Duration of services (based on continued health plan eligibility):

Start Date:__________ ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (Chronic condition only)

Justification

Transportation under California Health & Wellness Plan is covered only when the patient's medical and physical condition does not allow him or her to travel by bus, passenger car, taxi, or other form of public or private conveyance. The physician is required to document the patient's limitations and provide specific physical and medical limitations that preclude the patient's ability to reasonably ambulate without assistance or be transported by public or private vehicles. Please document below:
What prevents the patient from traveling by bus, passenger car, taxi, or other form of public or private conveyance?

Certification

The physician, dentist or podiatrist responsible for providing care for the patient is responsible for determining medical necessity for transportation. This certificate can be completed and signed by a participating physician group (PPG), independent practice association (IPA), primary care physician (PCP), MD, LVN, RN, PA, NP, certified midwife, or discharge planner who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate.

Staff/physician's name (print): ______________________________

Staff/physician's signature: ____________________ Title: ____________________

Date: ____________________ Contact telephone: (_____) _____ –__________

Please return form by fax to Modivcare, Attention: Utilization Review at 877-457-3352.

CONFIDENTIALITY NOTE FOR FAX TRANSMISSION: This facsimile may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, or the person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or use of the information contained in this transmission is strictly PROHIBITED. If you have received this transmission in error, please notify the sender immediately by telephone or by return fax and destroy this transmission, along with any attachments.

Description of transportation services	
Gurney/litter/stretcher van	Patient is confined to a bed and cannot sit in a wheelchair but **does not require** medical attention or monitoring during transport.
BLS ambulance	Patient is confined to a bed, cannot sit in a wheelchair, and **requires** medical attention or monitoring during transport for reasons, such as: • Isolation precautions. • Non-self-administered oxygen. • Sedation.
ALS ambulance	Patient is confined to a bed, cannot sit in a wheelchair, and **requires** medical attention or monitoring during transport for reasons, such as: • IV requiring monitoring. • Cardiac monitoring. • Tracheotomy.
Critical care transport	Patient has a special condition that **requires** the presence of a critical care nurse or a medical doctor during transport.
Air transportation	**Requires** prior authorization from the plan.
Wheelchair van	Patient is a wheelchair user and **requires** lift-equipped or roll-up wheelchair vehicle.

200 Lincoln Way, Suite 200 Garden Grove, CA 92841
Phone: 1-866-666-8645 Fax: 1-877-457-3352

Consent for Minors to Travel without an Escort

1. I,____, residing at ____________________________
__________________________________(Address) hereby affirm that I am the Parent/ Legal Guardian of____________________________(name of minor.)(Child).
2. The Child is______________years old. The Child's date of birth is _________________. The Child's Medi-Cal number is ____________________________.
3. I hereby consent to the Child riding unaccompanied for medical and non-medical transportation with any transportation provider under contract to ModivCare.
4. I understand the risks that can be reasonably anticipated by medical and non-medical transport of the Child including possible medical equipment, aircraft, vehicle failure, traffic hazards, adverse weather conditions, pilot or driver error, interruption of medical treatment during transport, or consequences of actions of persons outside the control of transport personnel. I also understand the risks associated with the Child's condition including the possible worsening of the Child's condition during transport or the inability to fully treat or diagnose due to unavailability of more sophisticated medical equipment or facilities not normally available during transport. I consider the above risks of transport are outweighed by the advantage of the Child receiving transport.
5. By giving this consent and release of liability, I hereby represent that the Child is fully capable of being transported without an adult escort, will not be disruptive, will follow all rules communicated by the driver and does not need an escort to provide emotional or any other type of support.
6. I understand that if any of the factors set forth in paragraph 5, above, cease to apply, then ModivCare will no longer transport the minor without an escort.
7. I agree to inform ModivCare, within 48 hours if, for any reason, I cease being the Legal Guardian of the Child and to inform ModivCare of the name and address of the new Legal Guardian.

In consideration of ModivCare's agreement to transport the minor without an escort, I hereby release ModivCare and its employees, officers, agents and subcontractors from any and all liability, caused of actions, or claims, in connection with the Child's transportation by ModivCare and its subcontractors. I understand the content of this form and have been notified of the risks of transport.

Mail the completed form to the address listed above or fax to the fax number listed above. The completed form must be on file at the ModivCare office for any trips to be set up without an escort for the Child. Once a completed consent form is on file, it is considered to be active and valid for all transports until the consent is withdrawn.

____

____

SIGNATURE OF GUARDIAN
DATE

____

PRINTED NAME OF GUARDIAN

____

NAME OF MINOR TO WHOM THIS CONSENT APPLIES

____

____

WITNESS SIGNATURE
DATE

____

PRINTED NAME OF WITNESS

I have accurately and completely read the foregoing document to Parent/Legal Guardian in____________________________(insert language), the Parent's/Legal Guardian's primary language. He/she stated that he/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

____________________ ____

Date Name of Translator

For internal use only:

……………………………………………………………………………………………
…………………………………………

____

____

DATE RECEIVED BY MODIVCARE

____

NAME OF MODIVCARE STAFF MEMBER