Hardship Mileage Program

If you or a family member has Medicaid or Dr. Dynasaur the Medicaid program will help you get to doctor appointments or to pick up prescriptions. The Hardship Mileage Program is for people who:

- Have a car, and
- Drive to appointments over 50 miles per week (Sunday to Saturday), or
- Drive over 215 miles per calendar month.

The following people may be paid Hardship Mileage:

- A natural or adoptive parent of a child less than 18 years of age.
- Someone living in your house using your car.

All trips must be arranged with your Transportation Provider ahead of time. Your Provider will need to get approval from the Department of Vermont Health Access (DVHA) for any trip over 60 miles or any trip out-of-state. You will not be paid for trips that do not meet all transportation guidelines.

To be paid Hardship Mileage, you must fill out and send in a Trip Manifest to your Provider who will advise you of the current rate.

How it works:

- It is up to you to plan your doctor appointments, etc. so the least number of trips are needed.
- If the trip is out-of-area or out-of-state, your doctor must complete a Physician Referral Form at least 10 days before the appointment.
- Keep track of the trips you took to see your doctor or to pick up prescriptions on your Trip Manifest.
- Get proof that you saw your doctor or picked up a script.
  - Proof may be a script receipt, the doctor's signature on your Trip Manifest, or a signed note on your doctor's letterhead.
- Send in the Trip Manifest and proof of your trips to your Provider at the end of each month.
  - The Trip Manifest must be sent in within 30 days from the last visit in a calendar month. If the manifest includes all the information from a specific trip, all of those trips will be included in the payment as long as the manifest is submitted within that 30 day window from the date of the last leg of the specific trip.
    - Make sure to sign your Trip Manifest.
- If the trips meet Hardship Mileage rules, the Provider will send you a check.

- Before Hardship Mileage is paid your Provider <u>will make sure</u> the mileage is correct using Google Maps.
- Trips to the Emergency Room are not covered by Hardship Mileage.
- DVHA may deny payment of Hardship Mileage based on your family's income.

Revised 1.1.20

Waiver of Liability: Hardship Mileage

Member Name _____ Medicaid ID# _____ DOB _____

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I, own and drive a vehicle. I can drive myself or _____ to and from doctor appointments or to pick up prescriptions.

If I have been allowed to have my own driver I understand and agree to the following:

I understand that the only responsibility of the Vermont Public Transportation Association (**VPTA**) is to pay me at rates set by the Department of Vermont Health Access (DVHA). I waive any and all claims against the **VPTA** and its employees and directors arising from injury, damage, expense, or loss which may arise from driving myself or a family member to doctor appointments or to pick up scripts. I also understand that it is my sole responsibility to follow all laws governing vehicles and drivers. This waiver is binding on me, my family and my heirs, assigns, executors and administrators and applies to all Medicaid rides where I have chosen my own driver.

- I understand that I may consult an attorney regarding this waiver.
- By signing below, I agree that I have carefully read this document, or had it read to me, and understand and agree with its terms.
- I understand this waiver will not apply in the future if I have the VPTA provide rides for me.

_____ _____

Signature of Member or Parent/Legal Guardian if minor Date

_____ _____

Signature of Witness Date

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Department of Vermont Health Access
208 State Drive, NOB 1 South
Waterbury, VT 05671-1010
Phone: (802) 241-9300
Fax: (802) 879-5919

Physician Referral Form

Please fax this form to 802-879-5919.

The Department of Vermont Health Access (DVHA) helps people on Medicaid or Dr. Dynasaur with transportation to get to their Medicaid-billable appointments or pick up prescriptions. If the requested trip is over 60 miles from a member's home, please complete and sign this form in order for us to determine if this trip should be covered by Medicaid.

Member Name:_____ DOB: _____

Medicaid ID #: _____ Phone Number: _____ Member Email: _____

Appointment Date and Time: _____

Name of Primary Physician: _____

Name of Physician to whom
Member is Being Referred to:_____

If Applicable, Facility Name: _____

Address: _____

_____

Phone: _____

Is this the closest provider available to where the member resides? Yes ☐ No ☐
If no, please explain why on second page.

Is overnight lodging necessary outside of a hospital? Yes ☐ No ☐
If yes, please specify the dates requested for lodging: _____

Medically, how many people should accompany the patient (including the driver)? _____
Please explain on next page.

DVHA USE ONLY - Authorized By: _____ Date:_____

Approved ☐ Hardship ☐ Under 60 Miles ☐ Denied ☐

Lodging ☐ Dates _____ Meals ☐ If meals, # of people_____ Parking/Tolls ☐

1. Please describe the specific service or medical care that this member needs a ride to:

_____

_____

2. If this is not the closest provider, please explain medically why the member cannot be seen closer:

_____

_____

3. Please explain in detail if there is medical necessity for someone to accompany the member:

_____

_____

4. Does the member have a history with this specific provider? Yes ☐ No ☐
   If yes, how long? _____

5. If a history exists with this provider, please explain why the care cannot be transferred closer:

_____

_____

6. If this is an out-of-state/out-of-network request, please answer the following:

   Does this member have a primary insurance? Yes ☐ No ☐
   If no, a clinical prior authorization may be needed before this transportation request can be considered. For questions pertaining to this process please call 800-925-1706.

7. If necessary, please add any further information: _____

_____

_____ _____ _____

Print name of Doctor or Doctor's Staff providing information Phone Fax

_____ _____

Signature of Doctor or Doctor's Staff providing information Date

Hardship Cheat sheet

-Make sure you have all proof of appointments with your manifests prior to turning them in or you will not be reimbursed for the trip.

- Make sure you turn in all manifests by the 5th of the next month. (Example: turn in all January manifests by February 5th)

-Make sure you write down the beginning and ending odometer readings on your manifest for every part of your trip.

-Make sure you call in any and all trips to the call center (540-2589) prior to the date of your trip(s).

-Make sure you get a physician referral form (for any and all trips over 60 miles 1-way from your home) filled out by your primary doctor and faxed to Medicaid at least 10 days prior to your trip so we have time to get it back approved by Medicaid or you will not receive a manifest.

-You will only be reimbursed once a month if you reach 215 miles for the month.

-Trips to the Emergency Room are **NOT** covered by Hardship Mileage.

Any questions or concerns please feel free to call.

Washington County (Donna 262-6182)

Franklin County (Broker Services 540-0711)

Hardship Check-off List

☐ Hardship waiver of liability form _____

Forms Given to Hardship client sign that you received

☐ Hardship form for driver

Date: _____ _____

☐ Hardship cheat sheet for driver

Date: _____ _____

☐ Physician Referral form

Date: _____ _____

☐ Sample Manifest

Date: _____ _____

We have gone over everything and answered all your questions:

_____

Signature _____

Sign it

Scheduled Trips Summary - GMTA

For Time Period: 2/27/2018

Printed: 2/15/2018 1:31:34PM

Run Name: Unassigned **Vehicle:**
Driver Name:

Customer Name	Pick Up Time	Pick Up Address	Drop Off Time	Drop Off Address	Mobility Type	Customer Pay	Telephone Ext.
	1:45:00PM		2:00:00PM		Ambulatory	$ 0.00	

Request Time: 2:00 pm
Funding Source: Medicaid
Assistance Needs:

Beginning odometer reading _____

Ending odometer reading _____

Drive Time [ ] Miles [ ]

	3:00:00PM		3:15:00PM	Fill IN	Ambulatory	$ 0.00	Fill IN

Request Time: 3:00 pm
Funding Source: Medicaid
Assistance Needs:

Beginning odometer reading _____

Ending odometer reading _____

Drive Time [ ] Miles [ ]