NON-MEDICAL TRANSPORTATION –PER TRIP

Provider: _____ Provider#: _____ Vehicle License#: _____ Month: _____ Year: _____

NON-MEDICAL TRANSPORTATION DAILY DOCUMENTATION PER-TRIP (1 Unit)

Date	Driver's Initials	Pick up time	Drop-off Time	Modified Vehicle Rate (Y/N)	Billing Units	Passengers	Medicaid #	Other Paid Staff or Riders

Driver's Signature: _____ Initials_____ Driver's Signature: _____ Initials_____

Driver's Signature: _____ Initials_____ Driver's Signature: _____ Initials_____

DAILY INSPECTION ON BACK (IF REQUIRED)

NON-MEDICAL TRANSPORTATION –PER TRIP

NON-MEDICAL TRANSPORTATION DAILY INSPECTION CHECKLIST

DAILY INSPECTION ONLY REQUIRED ON MODIFIED VEHICLES OR VEHICLES EQUIPPED TO TRANSPORT 5 OR MORE PASSENGERS

DAILY CHECKLIST (circle response)	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DATE OF SERVICE							
Belts/Fasteners	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Lift/Ramp	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Seat Belt Fastened	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Horn	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Tires	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Windshield	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Washer/Wipers	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Emergency Equipment	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Mirrors	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Brakes	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Date problems were fixed:							
Driver's Initials:							

Date	Notes	Initials