MGH Social Service Department

MassHealth PT-1 Application Assistance

Inpatient Med/Surg - **Non-Oncology** patients

Instructions for Social Service Department Staff

1. **Use this service if provider agrees that PT-1 transportation is needed, but cannot/will not complete the PT-1 (and, if applicable, receiving facility will cannot/will not complete).** Please encourage the provider to apply for an account now to prepare for future needs. We can share provider training materials on request.
2. **Complete the referral form (below)** with information from the authorized provider and the patient or caregiver. Note: rides to more than one building will require separate PT-1s.
3. The Med/Surg Resource Specialist will submit the PT-1, check for approval and **will educate patient/family to use the service to arrange rides, unless you check-off on form that you'd prefer to.**
4. Questions? Email Grace Santana or call 617-643-8327.

Social Service Department MassHealth PT-1 Application Assist – **Inpatient MED/SURG**

CRC Referral Form

Patient's Name _____ **DOB or MRN** _____

MassHealth number (if available) _____

Ask Patient/Caregiver

Can family or friend transport for full duration of treatment? ☐ Yes ☐ No

Pick-Up Address (**please ask patient**, as it may differ from Epic address):

_____

Patient Phone number (required) _____

Needs (Check all that apply. NOTE: children will always need an escort.)

☐ **Escort** (How many_____) ☐ **Standard Wheelchair** ☐ **Electric Wheelchair**

☐ **Door to Door Trip** (member requires assistance holding the door; navigating a path)

☐ **Service animal** ☐ **Single ride*** ☐ **Sedan*** ☐ **Front seat only***

☐ **Other*** _____ *requires additional documentation

Emergency contact name & phone (optional): _____

Ask Authorized Provider (MD, NP, PA, Nurse midwife, psychologist, dentist, etc.)

☐ **PT-1 is necessary, provider cannot/will not arrange, and authorizes us to do so**

Authorizing provider name and contact _____

Treating provider name _____

MGH building (for treatment) _____

Medical treatment type (ICD 10 Dx OR SUD Tx) _____

Number of visits _____ ☐ per week **OR** ☐ per month

Expected duration of treatment (# of weeks or months) _____

Next appointment date _____

Live more than 25 miles from Boston? If yes- why cannot get equivalent care near home? (Examples: continuity of care, or specify services unique to MGH.)

_____

Can't take public transit due to: ☐ physical disability ☐ mental disability ☐other_____

Additional information or special requests? _____

Requested by (**MGH Social Service Department staff only**)

Name: _____ Date: _____

Preferred contact info:_____

☐ **Please share information with me and I will share with patient/family**

Please email completed form to Med/Surg Resource Specialist (**Grace Santana**).

For CRC Staff Use

Staff Name _____ Date submitted: _____

Approved Date: _____ ☐ Notified patient OR ☐ Notified SSD staff

Denied – reason and disposition _____