Medicaid Transportation Complaint/Referral Form

This information is directed to the NJ Division of Medical Assistance and Health Services, State Monitoring Unit (SMU) staff assigned to monitor the Medicaid transportation vendor ModivCare.

Date of complaint ____/____/_____ Trip #_____

Name of transportation company_____

Name of Skilled Nursing Facility (SNF)_____

Name of Resident _____

Transportation was booked by (check one)
☐ staff ☐ resident ☐ family/responsible party ☐ other

Scheduled pick up time at SNF _____ am / pm

Actual time of pick up at SNF _____ am / pm

Appointment time _____ am / pm **Arrival at appointment time**_____ am/pm

Return to SNF scheduled pick up time _____ am/pm

Actual pick up time _____ am/pm **Return to SNF time** _____ am/pm

Type of Complaint: (Check all That Apply)
___ Late Pick Up at Facility **How late?** ____ hour/s ____ minutes
___ No Show at Facility
___ Late Pick Up For Return **How late?** ____hour/s ____minutes
___ No Show for Return
___ Other: _____

Additional concerns, related to transportation, which may have negatively impacted the resident's quality of life: (e.g. – appointment cancelled – appointment had to be rescheduled – problems with behavior of driver – loss of needed medical care – problem reaching Call Center or any other concerns).

_____

_____

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_____

Name of person filing complaint: _____

Relationship: (e.g. resident, family member, N.H. staffer) _____

Resident or responsible party contact information_____

Resident/ Responsible Party has been advised of this referral to SMU, ModivCare Medicaid Unit ____ Yes