SOUTH COUNTRY
HEALTH ALLIANCE

CERTIFICATION OF NEED

SCHA requires the following for STS transportation to be completed by the provider and kept on file for 10 years. Prior authorization will not be required, unless requested by SCHA. SCHA will complete audits to assure compliance with procedures and standards.

Date of Request: ________________________

Member Name: __________________________ **Date of Birth:** _____________ **PMI#:** _________________

Diagnosis/Impairment: ____

1) Member resides in a Nursing Home? (Check one)... ☐ Yes ☐ No
   If yes, stop - member is exempt from this review. If no, complete the remainder of this form.

2) ☐ No, the member cannot be transported safely without escort by private auto, taxi or bus.
   - OR -

   ☐ Yes, the member can be transported safely without escort by private auto, taxi or bus.
   If yes, member does not qualify for STS - refer member to their county financial worker.

Please specify member's physical or mental impairment that requires the member to use special transportation:

- ☐ Stretcher
- ☐ Permanent Wheelchair (Circle One)........................Electric - *or* - Manual
- ☐ Temporary Wheelchair (Circle One)........................Electric - *or* - Manual
- ☐ Ambulatory
- ☐ Ambulatory with Assistance (Circle One)...........Walker - *or* - Crutches - *or* - Cane
- ☐ Transfers (Circle One) ....Independently - *or* - Needs Assistance
- ☐ Other ____

Date of first ride: _____________________________ **Expected end date:** ___________________

Signature of STS Provider: ____

Title of STS Provider: _______________________________________ **Date:** _________________

Note: *Forms for members with permanent physical or mental disabilities need to be updated for changes annually from first ride. Forms for members utilizing STS for other physical or mental needs need to be updated every six months.*