ME Operations
400 Southborough Dr.
S. Portland, ME 04106

STANDING ORDER REQUEST FORM

At least one day per week, minimum 90 (ninety) days

Each section must be complete and submitted no later than 2 business days prior to the start date.

FAX # 877-637-9091 PHONE # 877-659-1305

Ordered By:	Title:	Phone #:
MaineCare covered service ☐ Yes ☐ No	☐ New Order ☐ Update Existing Order ☐ Terminate Existing Order	Fax #:
Member's Name:	MaineCare ID #:	DOB: ______/_____/_____

APPOINTMENT INFORMATION

Treatment Days ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ One Way ☐ Round Trip	Appt. Time: ________ ☐ AM ☐ PM Return Time: _______ ☐ AM ☐ PM	**Level of Service:** ☐ Ambulatory * ☐ Wheelchair *Wheelchair size ☐ **Regular** ☐ **Oversized**
	Start Date: _____/_____/_____ End date: _____/_____/_____	*If Wheelchair: **Member's Weight:______ Height:______** Able to transfer to vehicle ☐ **Yes** ☐ **No** Stair: ☐**Yes** ☐ **No** Wheelchair fold: ☐ **Yes** ☐ **No**
	Treatment Type: ☐ Day Support ☐ Dialysis ☐ Supported Employment ☐ Chemo/Radiation ☐ Physical Rehabilitation ☐ Case Management ☐ Counseling ☐ Therapy Type: __________________ ☐ Substance Abuse (15 min appt.) ☐ If Other specify: Treatment: ________________ waiver section: ______________	☐ Mass Transit(bus passes) ☐ Mileage Reimbursement (complete next two lines) Driver Name:______________________________________ Mailing address: __________________________________ ☐ Needs Transportation Escort traveling with member? ☐ **Yes** ☐ **No** Can the Member sign the driver's log? ☐ **Yes** ☐ **No** Door to Door ☐ **Yes** ☐ **No** Can't leave unattended ☐ **Yes** ☐ **No** **Important information/special needs for the member**:

PICK-UP INFORMATION

Complex Name:	Adult Shared Living: ☐ **Yes** ☐ **No** Residential Care Housing: ☐ **Yes** ☐ **No** Group Home: ☐ **Yes** ☐ **No**
Residence Address/Apt #:	City, State Zip:
Phone #:	Emergency Name & Phone #:

DROP-OFF INFORMATION

Facility/Complex Name:	Provider Name:
Address/Suite/Bldg. #:	City, State Zip:
Phone #:	Alternate Phone #:
Additional trip information:	

Visit the website for facilities at https://Tripcare.logisticare.com to input your own standing orders, single trip requests or to do monthly attendance.

Signature: ________________________________ **Date**: _________________

"Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose."