Ohio Department of Medicaid
Non- Emergency Transportation Report

Year:	Quarter:	☐ 1st (Jul-Sep) ☐ 2nd (Oct-Dec) ☐ 3rd (Jan-Mar) ☐ 4th (Apr-Jun)	County:
Preparer's Name:		Phone:	Fax:

Part A

Reimbursable Transportation Expenditures	Number of Unduplicated Consumers	Number of One-Way Trips	Expenditures	Mileage (if applicable)
Bus, Rail, etc. (Fixed Route)				
Friend or Relative				
Consumer				
CDJFS Vehicles				
CDJFS Personal (Own Vehicle)				
Attendant				
Travel Expenses				
Totals				

Part B

Contract Vendor (Name)	Number of Unduplicated Consumers	Number of One-Way Trips	Expenditures	Mileage (if applicable)
Totals				

Total Sum of Part A and Part B	Number of Unduplicated Consumers	Number of One-Way Trips	Expenditures	Mileage

During the quarter for which county is reporting, did any non-emergency transportation become an emergency? ☐ Yes ☐ No

If so, how many emergencies did the county respond to? ☐

CDJFS Director Signature:	Date: