J Trans
Application for Transportation Disadvantaged Eligibility

SECTION 1 - DETERMINATION OF ELIGIBILITY

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

County _____ Telephone # _____ TDD # _____

Sex: Male / Female DOB _____ SS# _____ Medicaid # _____

Emergency Contact: _____ Relationship _____ Phone# _____

Total Monthly Household Income: $_____ **Total # of Household Members:** _____

Other Household Members that USE J Trans: (Please list each member, use separate sheet if necessary)

NAME	SEX: M/F	DOB	SS#	MEDICAID #	RELATIONSHIP

SECTION 2 - AVAILABILITY OF SUITABLE MODE OR TRANSPORTATION TO OTHER COMMUNITY LOCATIONS

Answer Yes/No

_____ Do you own a vehicle? Year _____ Model _____
_____ Do you have a valid FL Driver's License? DL# _____
_____ Could you drive your vehicle to medical appointments? If not, explain below.
_____ Does any member of your household have a vehicle? Name _____
_____ Could they transport you to medical appointments? If not, explain below.
_____ Do you have family members in the county who can transport you? Name _____
_____ Could they transport you to medical appointments? If not, explain below.
_____ Do you have friends in the county who can transport you? Name _____
_____ Could they transport you to medical appointments? If not, explain below.
_____ Do you live in a facility that provides transportation?
_____ Could this facility transport you to medical appointments? If not, explain below.

Explain: _____

Please explain how you previously got to your medical appointments. _____

SECTION 3 - AVAILABILITY OF FEDERALLY FUNDED TRANSPORTATON

Yes / No Are you enrolled in any other programs that will pay for or provide transportation? If ***YES***, please describe them below.

_____ Transportation Disadvantaged Other: _____

Revised 10/07/06

Complete Other Side

SECTION 4 - SPECIAL NEEDS

Please check or list any special needs, services, or modes of transportation you require during transportation:

_____ Manual Wheelchair _____ Power Wheelchair _____ Walker _____ Cane

_____ Respirator _____ Service Animal _____ Personal Care Attendant (PCA)

_____ Amputee _____ Stretcher _____ Cultural Considerations (Please explain below)

Other: _____

SECTION 5 - CERTIFICATION AND ACKNOWLEDGEMENT

I understand and affirm that the information provided in this application for Transportation Disadvantaged services is true and correct, to the best of my knowledge, and will be kept confidential and shared only with medical and transportation professionals involved in evaluating and determining my needs and eligibility of transportation to and from eligible services and appointments. I understand that providing false or misleading information, or making fradulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida.

Applicant Signature _____ Date _____

PLEASE RETURN THIS FORM TO:

J Trans
P.O. Box 1117
Marianna, FL 32446

Tel: (850) 482-7433 TDD#: (850) 482-6261
FAX: (850) 482-8582

SECTION 6 - RESULTS OF INTERVIEW

DO NOT WRITE IN THIS SPACE - OFFICIAL OFFICE USE ONLY

New Eligibility Application: Yes / No Redetermination: Yes / No

Date Approved: _____ Date(s) of Service: _____

Date Denied: _____ Reason for Denial: _____

Mode: _____ PCA Needed: Yes / No

Date Received _____ Date Completed _____ Reviewer _____

Complete Other Side