J Trans

Application for Transportation Disadvantaged Eligibility

SECTION 1 - DETERMINATION OF ELIGIBILITY

First Name: _____ MI: _____ Last Name: _____

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 _____
_____ 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? Name _____
_____ 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 (ie: Medicaid) that will pay for or provide transportation? If ***YES***, please lsit below.

Managed Care Provider: _____ Other: _____

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Complete on Other Side

SECTION 4 - SPECIAL NEEDS/DISABILITY

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

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

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

_____ Stretcher _____ Walker _____ Manual Wheelchair _____ Power Wheelchair

_____ Power Scooter _____ Disability (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

DO NOT WRITE IN THIS SPACE - OFFICIAL OFFICE USE ONLY

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

Reason for Approval:

Income: _____ Disability: _____ Age: _____

Date Denied: _____ Reason for Denial: _____

Date Received _____ Reviewer _____

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