J Trans

Application for Transportation Disadvantaged Eligibility

Section 1: General Information			
First Name:		Middle Initial:	Last Name:
Date of Birth:	Sex: ☐ Male ☐ Female	SS #:	Medicaid #:
Phone #:		Email:	
Street Address:		Bldg/Apt #:	
City:		State:	Zip:

Type of Residence:
☐ House ☐ Apartment ☐ Mobile Home ☐ Nursing Home/Rehab Center ☐ Assisted Living
☐ Other:_____

Other Minor Household Members that need JTrans: (each adult must have their own application)

Name:	Sex: M/F	DOB:	SS#:	Medicaid #:

Emergency Contact:

Name:	Relationship:	Phone #:

Please indicate why you are seeking Transportation Disadvantaged eligibility (check all that apply).
*One of these criteria must be met and proof submitted in order to qualify for services under this program.

☐ I am age 60 or older (proof of age is required – i.e.: state ID).
☐ My income level falls below current federal poverty guidelines of 200% (proof of income is required).
☐ I have a disability (proof of disability is required).
☐ Other (please specify): _____

Special Assistances/Mobility Aids:			
☐ Amputee	☐ Cane	☐ Crutches	☐ Escort/Assistant
☐ Hearing Impairment	☐ Mental Disability	☐ Portable Oxygen	☐ Service Animal
☐ Stretcher	☐ Walker	☐ Rollator Walker	☐ Electric Scooter
☐ Manual Wheelchair	☐ Power Wheelchair	☐ Visual Impairment	☐ Other:
Does your residence/facility have a ramp?: ☐ YES ☐ NO			
Please explain:			

Section 2: Verification of Income	
Total Monthly Income:	Total # Household Members:
How many vehicles are owned/used by members of household?	
Are the(se) vehicle(s) available for use?	☐ YES ☐ NO

If not, please explain:	

Please submit one of the following as proof of income with completed application:

- 1st page of tax return
- Social Security Income Verification
- Dept of Children & Families Benefit Letter
- Recent Pay stubs
- HUD/Section 8 letter
- Retirement/Pension Statement
- Unemployment Income Verification

Section 3: Medical Verification	
Has the applicant been diagnosed with a cognitive, mental, physical, or other disability requiring the use of JTrans services? ☐ YES ☐ NO	
☐ Permanent Disability	☐ Temporary Disability

Please submit one of the following as proof of disability with the completed application:

- SSI/Disability Statement
- VA Disability Statement
- Diagnosis Code/Face sheet from medical facility
- Doctor statement (see attached)

Applicant Certification:
I certify the information provided in this application is true and correct to the best of my knowledge, and will be kept confidential and shared only with the medical and transportation professionals involved in evaluating the determining my needs. I understand that providing false or misleading information, or making false statements on behalf of others constitutes fraud and is considered a felony under the laws of the State of Florida.

Applicant Signature: _____ Date: _____

PLEASE RETURN TO:
JTrans
PO Box 1117
Marianna, FL 32446
Ph: 850-482-7433 Fax: 850-482-8582

Section 4: Results		
DO NOT WRITE IN THIS SPACE – OFFICIAL USE ONLY		
Date Approved:	Dates of Service:	
Reason for Approval:		
☐ Age	☐ Disability	☐ Income
Date Denied:	Denial Reason:	
Date Received:	Reviewer:	

Section 3: Medical Verification or Disability Statement
This form must be completed by a medical professional if you are applying for Transportation Disadvantaged (TD) Service due to a medically verified physical or cognitive condition, impairment, or disability.

Dear Medical Professional:

In order to process this applicant's request for JTrans service eligibility, we require this form be completed. Only licensed medical professionals or designee having knowledge of the applicant's functional ability to us JTrans service should complete this form.

Many of our vehicles are wheelchair accessible and equipped with wheelchair lifts/ramps. Therefore, use of a wheelchair does not automatically make an applicant eligible to use JTrans services.

Thank you for your assistance.

Applicant Name:	Date of Birth:
Part A: Has this person been diagnosed with a cognitive condition or mental or physical impairment or disability requiring the use of JTrans' service? ☐ YES ☐ NO	
Part B: Is the disability: ☐ PERMANENT ☐ TEMPORARY – if temporary, how long?	

MEDICAL PROFESSIONAL INFORMATION		
Medical Professional's Name & Title:		
FL License #:	Email:	
Business Address:	Suite #:	Building #:
City:	State:	Zip:

Medical Certification

In signing, I acknowledge that, to the best of my knowledge, the information in the evaluation form is true and correct. I understand that providing false or misleading information could result in the re-examination of the eligibility status of the applicant as well as prosecution to the maximum extent allowed by the laws of the State of Florida.

Medical Professional's Signature: _____ Date: _____