ST JOHNS COUNTY COUNCIL ON AGING
NON-EMERGENCY TRANSPORTATION (NET) PROGRAM
BENEFICIARY INTAKE FORM

SECTION 1 – DETERMINATION OF ELIGIBILITY

LAST NAME _____ FIRST NAME _____ MI _____ MEDICAID # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____

DOB ____/____/____ SEX ____ SS# _____-_____-_____ TELEPHONE # (_____) _____-_____ TDD # (_____) _____-_____

EMERGENCY CONTACT _____ RELATIONSHIP _____ TELEPHONE (_____) _____-_____

OTHERS HOUSEHOLD MEMBERS *(Please list each member)*	NAME	RELATIONSHIP	AGE	DRIV. LIC (Y/N)	TYPE OF VEHICLE

SECTION 2 – AVAILABILITY OF SUITABLE MODE OF TRANSPORTATION TO OTHER COMMUNITY LOCATIONS

YES / NO

1. _____ Do you own a car? — Year _____ Model _____
   _____ Do you have a valid Florida Driver's License? — DL#: _____
   _____ Could you drive your car to medical appointments? — If not, why? _____
2. _____ Does any member of your household have a car? — Name: _____
   _____ Could they transport you to medical appointments? — If not, why? _____
3. _____ Do you have family members in the county who can transport you? — Name: _____
   _____ Could they transport you to medical appointments? — If not, why? _____
4. _____ Do you have friends in the county who can transport you? — Name: _____
   _____ Could they transport you to medical appointments? — If not, why? _____
5. _____ Do you live in a facility that provides transportation?
   _____ Could this facility transport you to medical appointments? — If not, why? _____

6. Please list all Hospitals, Doctors, Medical Facilities or other locations that you visit on a regular basis:

NAME OF HOSPITAL/DOCTOR/FACILITY	Purpose Of Trip	NUMBER OF MONTHLY VISITS	DESCRIBE HOW YOU PREVIOUSLY GOT THERE

SECTION 3 – AVAILABILITY OF FEDERALLY FUNDED OR PUBLIC TRANSPORTATION

YES / NO

1. _____ Do you live on a bus route? What is the distance to the nearest bus stop? _____
2. _____ Have you used the bus system for transportation in the past?
2. _____ Do you have any limitations that would prevent you from using the bus system now? If *YES*, please describe them below.

_____

3. _____ Are you enrolled in any other programs that will pay for or provide transportation? If *YES*, please describe them below.

_____

SECTION 4 – SPECIAL NEEDS
Please check or list any special needs, services or modes of transportation you require during transportation:

_____ Powered Wheelchair _____ Stretcher _____ Manual Wheelchair _____ Walker
_____ Cane _____ Respirator _____ Service Animal _____ Personal Care Attendant (PCA)
_____ Cultural Considerations (Please explain)

_____

Other: _____

_____

_____

SECTION 5 – Income Status (for CTD or County Grant applicants applying based on income):

Household Size (include adults and dependents)
Annual Income Or
Monthly Income

SECTION 5 – CERTIFICATION AND ACKNOWLEDGEMENT
I understand and affirm that the information provided in this application for CTD Transportation Disadvantaged and/or other Non-Emergency Transportation (NET) 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 for transportation to and from TD or other eligible services and appointments. I understand that providing false or misleading information, or making fraudulent 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:

St. Johns County Council on Aging, Inc.
Transportation Department
2595 Old Moultrie Rd.
St. Augustine, FL 32086

Phone: (904) 209-3710 Fax: (904) 794- 2239 TDD: Call the Florida Relay System @ 711

SECTION 6 – RESULTS OF INTERVIEW

DO NOT WRITE IN THIS SPACE – OFFICIAL OFFICE USE ONLY

NEW ELIGIBILITY APPLICATION: _____ (Y/N) REDETERMINATION: _____ (Y/N) DATE RECEIVED: _____/_____/_____ REVIEWED BY: _____

APPROVED DATE: _____/_____/_____ DENIED DATE: _____/_____/_____ REASON FOR DENIAL: _____ LETTER: _____ (Y/N)

MODE: _____ PCA NEEDED: _____ (Y/N) DATE OR DATES OF SERVICE: _____