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

Section 1 – Determination of Eligibility

Last Name		**First Name**			
Middle Ini.		**Medicaid #**			
SS #		**DOB**		**Sex**	

Address		**Apt/Unit #**	
City & State		**Zip Code**	
Primary #	**TDD #**		

Emergency Contact	**Last Name:**	**Relationship**	
	First Name:	**Contact #**	

Other Household Members *(Please list Each Member)*

Name	Relationship	Age	Driv. Lic. (Y/N)	Type of Vehicle
1.				
2.				
3.				
4.				
5.				

Section 2 – Availability of Suitable Mode of Transportation to Other Community Locations

YES/NO	Question	If Applicable	
	1. Do you own a car?	Year:	Model:
	Do you have a valid FL 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?	

Section 2 – *CONTINUED*

YES/NO	Question	If Applicable
	5. Do you live in a facility that provides transportation?	Name:
	Could this facility transport you to medical appointments?	If **not**, why?

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

Name of Hospital/Doc./Facility	Purpose of Trip	# of Monthly Visits	Describe How You Previously Got There

Section 3 – Availability of Federally Funded or Public Transportation

YES/NO	Question	If Applicable
	1. Do you live on a bus route?	Name:
	What is the distance to the nearest bus stop?	Approx. Miles:
	2. Have you used the bus system for transportation in the past?	
	3. Do you have any limitations that would prevent you from using the bus system now?	If **yes**, please describe:
	4. Are you enrolled in any other programs that will pay for, or provide, transportation?	If **yes**, please describe:

Section 4 – Special Needs *(Please check or list any special needs, services, or modes of transportation you require during transportation):*

__Powered Wheelchair __Manual Wheelchair __Scooter __Stretcher
__Respirator/Oxygen __Service Animal __Cane __Walker Needs Lift
__Cultural Considerations *(Please Explain)* __Escort (PCA) __Ambulatory

_____

Other: _____

_____

Section 5 – Income Status *(for CTD, County, or Rural Grant Applicants applying based on income)*

Self (Monthly Income)	***$ /Month***
Household Member 1. (Monthly Income)	***$ /Month***
Household Member 2. (Monthly Income)	***$ /Month***
Household Member 3. (Monthly Income)	***$ /Month***
Household Member 4. (Monthly Income)	***$ /Month***
Household Member 5. (Monthly Income)	***$ /Month***
Total Number of Household Members:	***Total $ /Month***
	(x 12 months)
Total Annual Income for Household	***Total $ /Annual***

Section 6 – 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** **Email: customerservice@stjohnscoa.com** **TDD: Call the Florida Relay System @ 711**

Section 7 – Results ~~~~~**FOR OFFICE USE ONLY – DO NOT WRITE IN THIS SPACE**~~~~~

Date Received: ____/____/____ New Application (Y/N): ___ Redetermination (Y/N): ___

Mobility: _____ Escort (Y/N)?: ___ Approved? ☐ Yes ☐ No Date: ____/____/____

FS Sponsor: _____ If No - Reason for Denial: _____

Reviewed By: _____ Denial Letter Sent? (Y/N): _____