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: ____________________________________