BCCOA TRANSPORTATION DISADVANTAGED ELIGIBILITY APPLICATION

The Transportation Disadvantaged Program was established to provide transportation services to the elderly, disabled, economically disadvantaged, children at risk and to individuals who have no other forms of transportation. It is our goal to provide citizens with safe, reliable, convenient, affordable and cost efficient public transportation. For more information, please call BCCOA transportation department at 904-259-9315.

Section 1 – Personal Information

LAST NAME: _____ FIRST NAME: _____ MI:_____

ADDRESS: _____ CITY:_____ STATE:____ZIP_____ COUNTY_____

DOB:____/___/___ GENDER:_____ SS#:____-___-___ PHONE: _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE:_____

Section 2 – Household Member Information

HOUSEHOLD MEMBER & TOTAL HOUSEHOLD INCOME:

NAME & RELATIONSHIP	AGE	MO. INCOME	DRIV. LIC.(Y/N)	MAKE/YEAR VEHICLE	RECEIVE FOOD STAMPS YES	NO	VETEREN?
_____	____	$_____	_____	_____	____	____	_____
_____	____	$_____	_____	_____	____	____	_____
_____	____	$_____	_____	_____	____	____	_____
_____	____	$_____	_____	_____	____	____	_____
_____	____	$_____	_____	_____	____	____	_____

Section 3 - Availability of Transportation

1. What type of vehicle do you own? Year:_____ Make:_____ _Model:_____ N/A:_____
2. Is there a reason why you cannot drive your car? Yes/No. If yes, can you tell us if it is medical___ or because you are having vehicle troubles?___ Will the transportation services be temporary ___ or permanent?___ (Please explain below)….
   _____
   _____
3. Does any other member of your household own a vehicle? YES_____ NO_____
4. Could anyone in your household, family or friends transport you to your appointments? YES____ NO_____ If no, why?
5. How are you currently being transported to your appointments?_____
6. Are you aware that you are required to pay a co-payment for this program? YES____ NO____
7. Do you receive VA benefits for transportation? YES____ NO____

Section 4 – Information About Recurring Medical Appointments

Main Purpose of Appointment _____
Dialysis___ Oncology___ Physical Therapy___ Other_____
Anticipated Appointment Time:_____ Length of Appointment:_____ Days of Week:_____
Anticipated Appointment Time:_____ Length of Appointment:_____ Days of Week:_____

Section 5 – SPECIAL NEEDS

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

_____ Powered Wheelchair _____Stretcher _____Manual Wheelchair _____Walker
_____ Respirator _____ Service Animal _____Escort ____ Cane

Section 6 – Certification and Acknowledgement

I understand and affirm that the information provided in this application for CTD Medicaid 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 for transportation to and from medical 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:_____

BAKER COUNTY COUNCIL ON AGING
TRANSPORTATION DEPARTMENT
9264 Buck Starling Rd.
Macclenny FL. 32063
Mailing Address: P.O Box 1559
Macclenny FL. 32063

904-259-9315 TDD 1-800-983-8435

Section 7 – OFFICIAL USE ONLY

DO NOT WRITE IN THIS SPACE

* * * * * * * * * * * * * * * * * *

New Application:___Recert:___ TD___ 5310___PP___Medicaid___ A2C___ LOG___MTM___Other____

Approved Date: _____ Denied Date: _____ Reason for Denial:_____

Worker_____ Date:_____ Supervisor:_____Date:_____