

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	
Phone #	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?	

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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: _____

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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
<i>(x 12 months)</i>		
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 @

Section 7 – Results 711 **~~~~~ 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): _____