CLAY TRANSIT ____TD _____MMA _____US Veteran

Assessment Screening Form 2018 ____ Bus Pass _____5310 ____5311

To determine eligibility for Transportation Services under TD program- 5310-5311-Medicaid Managed Care

All Items must be completed and TYPED or PRINTED legibly or form will be denied

SECTION I – INDENTIFYING INFORMATION

Medicaid No.:_____ S.S. #_____Phone#:_____

Last Name: _____First Name:_____

Home Street Address: _____Bldg #____Apt.#:_____

(Need address # on house or mail box to locate at pick up)

Name of Sub-division or Apartment Complex: _____

City: _____Do you live in Clay County: __**Yes** __**No** Zip Code: _____

Is this a: _____ House ____ Apartment _____ Nursing Facility _____ ALF ____ Boarding Home

Date of Birth: ____/____/_____ Your Current Age: _____ _____ Male _____Female

Total Monthly Income $: _____ (optioinal)

Optional: __ White __ Black __ Hispanic __ Native American __ Asian __Other_____

SECTION II – NEED INFORMATION

Do you own a car?	___Yes ___ No
Are you able to operate an automobile, even for short distances?	___Yes ___ No
Does any member of your household have a car?	___Yes ___ No
Do you have any family or friend who lives in County who could transport you?	___Yes ___ No
Has this person(s) ever transported you to the doctor?	___Yes ___ No
Would this person(s) take you to the doctor if you ask them?	___Yes ___ No
What are your vehicle license plate(s) numbers(s)?	_____
Are you a U.S. Veteran?	___Yes ___ No

Must provide written documentation why the car is not available to you for transport

Total # of persons who reside in your household: _____

List Names: Name	**Is this person Related to you**	**Does this person Own a Car?**	**If cannot transport WHY?**
_____	___Yes ___No	___Yes ___No	_____
_____	___Yes ___No	___Yes ___No	_____

Can you walk without help to the distances ____ Across a room _____ One block ____ Two blocks or more

Can you ride one of the (7) Bus lines for Public Transportation offered by Clay Transit: __YES ____NO

This section must be completed if you live in an Assisted Living Facility, Nursing Home, ICFMR or Boarding Home.

Does this facility have a vehicle?	___Yes ___No
Have you ever been transported by the facility?	___Yes ___No
Do you know someone who would transport you if you paid for the gas?	___Yes ___No

SECTION III – DISABILITY

Are you currently receiving Supplemental Security Income (SSI)? ___Yes ___No
Are you currently receiving Social Security Disability? ___Yes ___No

Do you consider yourself to be disabled? If Yes, what is the nature of your disability?

NEED TO KNOW FOR TRANSPORT:

___ Blind/Legally Blind ___ Wheelchair User ___ Difficulty Walking
___ Arthritis ___ Cerebral Palsy ___ Multiple Sclerosis
___ Neuromuscular Disease ___ Alzheimer's disease ___ Stroke
___ Epilepsy ___ Mentally Challenged ___ Muscular Dystrophy
___ Respirator or Oxygen Dependent Do you have portable oxygen dispenser? ___Yes___No
___ Other: _____

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

(Check all that apply) ___ Scooter ____ Escort (one other person)
_____Service Animal ___Wheelchair ____Personal Care Attendant

___ Other _____

Are you able to drive yourself due to your disability? ___Yes___No If No Why ?_____

SECTION IV– FREQUENCY OF USE/DESTINATIONS

What doctors, medical clinics, or laboratory do you visit on a regular basis?

Name of Hospital, Doctor Or Clinic	Number of Visits Month or Week	Routine Day & Time	Describe How you Previously Got There

SECTION V – SIGNATURE, PREPARER AND WITNESS

I affirm that the information provided in this application for services is true and correct and understand that making false statements, having others make false statements, or making false statements on behalf of others constitutes welfare fraud and is considered **a felony under the laws of the State of Florida**.

Recipient's

Signature: _____ Date: ____/____/____

Preparer's Signature: _____ Date: ____/____/____

Do not Write In Space *Results of Interview* *Office Use Only*

NEW ELIGIBILITY_____REDETERMINATION_____DATE REC'D___/___/___REVIEWED BY:_____

APPROVED DATE____/____/____DENIED DATE___/___/____REASON FOR DENIAL_____

Return completed form to: ***Clay Transit***
604 Walnut Street
Green Cove Springs, FL 32043
Office: (904) 284-5977
Fax : (904) 284-5733
Website : www.claytransit.com

"like" us on facebook

Please, call our office once you have submitted the assessment to verify eligibility for transportation

FDOT Florida Commission for the CTD Transportation Disadvantaged Agency for Health Care Administration

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