Clay Community Transportation

Clay County Transportation
Medical Assessment Screening Form

All questions must be completed to process this application.

Eligibility Requirements

- Are 60 years of age or older
- Must have no other means of transportation available or cannot purchase transportation.
- No other funding sources can be available to provide them with transportation
- Are eligible if they are: disabled, or their household income is less than 150% of the Federal Poverty Guidelines (HHI) as established by the Department of Housing and Urban Development
- Must use flex route if available, and they have the ability to use.

If above requirements are met, please continue with filling out the application and submitting it to Clay Eligibility Office.

GENERAL INFORMATION (Please Print)

Last Name: _____First Name: _____ M. I.: ___
Medicaid # (Medical Trips Only): _____
Residential Address: _____Apt/Lot#_____
City: _____ State: _____ Zip: _____ County: _____
Is the provided address your mailing address? ☐Yes ☐No Email Address: _____
If not, please provide mailing address: _____
Daytime Phone Number: _____ Alternate Phone Number: _____
Date of Birth: _____ Gender: ☐Male ☐Female
Emergency Contact: _____ Relationship: _____ Telephone#: _____
If you live in a Facility, please list the name: _____
If you reside in a facility, does this facility have a vehicle? ☐Yes ☐No
If yes, can this facility provide you with transportation to medical appointments? ☐Yes ☐No
When you travel outside your home, please indicate which (if any) of the following mobility aids you use:

☐Power Wheelchair	☐Walker	☐White Cane	☐Service Animal
☐Wheelchair*	☐Cane	☐Respirator	☐Personal Care Assistant (PCA)
☐Scooter	☐Crutches	☐Lift	☐Other _____

*If you use a manual wheelchair, can you transfer to a passenger seat for travel? ☐Yes ☐No ☐N/A

State Transportation Disadvantage (TD) Program

1. Do you need trips/service for: ☐Medical ☐Non-Medical (or) ☐Both
2. Do you have a Driver's License? ☐Yes ☐No
If yes: License Number: _____ State: _____ Expires: _____
3. Do you or any member of your household own a vehicle? ☐Yes ☐No
List make, model and year for each: _____
4. Can you or a member of your household transport you to your appointments? ☐Yes ☐No
If not, why:
_____
5. Can you or a member of your household transport you to your shopping trips? ☐Yes ☐No
If not, why:
_____
6. Are you able to operate an automobile, even for short distances? ☐Yes ☐No

7. Please indicate the number of people (including yourself) residing in your household:

NAME	RELATIONSHIP	DOB	DRIVER LICENSE AND EXPIRATION DATE

8. Are you currently receiving dialysis or oncology (cancer) treatments? ☐Yes ☐No
If yes, how many times per week? _____.
Please provide the name of the facility where you receive these treatments: _____
9. If 60 years old or older, we can verify with ID. If under 60 years old, we must have either of the following:
☐Disability Letter (Letter from Doctor stating your Disability)
☐Household Income (Full Bank Statement or Previous Year Tax Return with Name & Address)
What is your total (monthly) household income? $_____
10. Are there any other transportation needs of which we should be aware including culture competency?
_____
11. Please attach a copy of the following:
☐Florida Driver's License -or- ☐Florida State Identification Card
☐Copy of a bill showing Name & Address (If address is not current on License or State ID)

APPLICANT SIGNATURE

I acknowledge the purpose of this application is to determine my ability to use transit and paratransit services. I understand that the staff of the Jacksonville Transportation Authority (JTA) and JTA Connexion may need to discuss my application to obtain additional information. I have been truthful in answering all these questions and my information may be verified. I authorize the health care professional, including psychiatrists or psychologists, designated in this application to release and provide JTA and JTA Connexion, or its representatives, any additional information that may be required to complete or clarify this application. I agree that, when possible, I will travel to the nearest location that can serve my needs and understand that this will allow JTA to most efficiently serve the needs of the community.

I certify that, to the best of my knowledge, the information given is correct.

Please note that any person who knowingly makes a false or misleading statement in an application or certification under section 320.0848, Florida Statutes, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or 775.083, F.S. The penalty is up to one year in jail or a fine of $1,000.

Applicant Signature:_____ Date:_____

If applicant signed their name above, but you helped this person to answer these questions, please sign and print your name below:

Signature: _____
Printed Name: _____
Relationship to Applicant: _____
Phone Number: _____

Please return completed application and applicable documentation to:

JTA Connexion Eligibility Center
100 N Myrtle Ave Building 2, Jacksonville, FL 32204
Phone: 904-284-5977