CLAY COMMUNITY TRANSPORTATION
MEDICAL/NON-MEDICAL ASSESSMENT SCREENING FORM

All questions must be completed to process this application.

ELIGIBILITY REQUIREMENTS

- Individuals cannot self-declare their eligibility; verification is required.
- Individuals that are 60 years of age or older are eligible if either:
  - Have no other transportation options,
    OR
  - Be unable to afford transportation (Household Income [HHI] guidelines may apply).
- Individuals under 60 years of age are also eligible if they:
  - Are disabled (e.g., documentation from a medical provider or agency such as the Social Security Administration or the Agency for Persons with Disabilities).,
    OR
  - Have a household income below 150% of the Federal Poverty Guidelines, as defined by HUD.
- No other funding sources (e.g., Medicaid, other programs) must be available to cover transportation.
- If a flex route is available and the individual can use it, they must use it.
- Riders must pay a co-pay per trip, as determined by the Local Coordinating Board (LCB).

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 address provided your mailing address? ☐Yes ☐No Email Address: _____

If not, please provide mailing address: _____

Home Phone: _____ **Cell** Phone: _____

Date of Birth: _____ Gender: ☐Male ☐Female

Emergency Contact: _____ Relationship: _____ Phone: _____

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	☐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. Are you needing 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 treatments? ☐Yes ☐No

If yes, how many times per week? _____.

Please provide the name of the facility where you receive these treatments: _____

9A. If 60 years old or older, we can verify with ID:

☐Have no other transportation options

☐Unable to afford transportation (Household Income [HHI] guidelines may apply).

9B. If under the age of 60, we must have either of the following:

☐Disability Letter (from medical provider or agency)

☐Household Income: What is your total (monthly) household income? $_____

10. Are there any other transportation needs which we should be aware of, 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 the 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