

**TRANSPORTATION DISADVANTAGED AND/OR
MEDICAID TRANSPORTATION DETERMINATION FORM**

All items must be completed and TYPED or PRINTED legibly or form will be returned

SECTION I - IDENTIFYING INFORMATION

Medicaid Gold Card No.: _____ S.S.# ____ / ____ / ____ Phone #: _____

Last Name: _____ First Name: _____

Home Street Address: _____ Apt. #: _____

Is this a: House Apartment Nursing Facility ACLF Boarding Home

City: _____ County: _____ Zip Code: _____

Mailing Address: _____

How may we contact you:

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

Total Monthly Income: _____

Optional: White Black Hispanic Native American Asian Other _____

SECTION II - NEED DETERMINATION

Are you eligible for Medicaid Non-Emergency Transportation? Yes No

Are you able to operate an automobile, even for short distances? Yes No

Do you or anyone in your household own a car? Yes No

What are your vehicle license plate(s) number(s)? _____

Total # of persons who reside in your household: _____ Please list below:

<u>Name</u>	<u>Is this person Related to you</u>	<u>Social Security No.</u>	<u>Does this person Own a car</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you lived in a Assisted Care 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 have any family or friends who live in the County you reside in? 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 asked them? Yes No

Do you know someone who would transport you if you paid for the gas? Yes No

Can you walk without help to the distances below? (Check those that apply)
 Across a room One block Two blocks Three blocks One mile

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? Yes No

If YES, what is the nature of your disability? (Check all the apply)

- Blind/Legally Blind Wheelchair User Difficulty Walking
- Arthritis Cerebral Palsy Multiple Sclerosis
- Neuromuscular Disease Alzheimer's Disease Stoke
- Epilepsy Respirator or Oxygen Dependent Other (describe)
- Muscular Dystrophy Mentally Challenged _____

Do you require mobility aids? Yes No

If YES, which aids do you require? (Check all that apply)

- Walker Guide Dog Personal Care Attendant
- Scooter Cane Wheelchair
- Other _____

SECTION IV - FREQUENCY OF USE/DESTINATIONS

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

**NAME AND ADDRESS OF HOSPITAL,
DOCTOR OR CLINIC** _____

**NUMBER OF VISITS
EACH MONTH OR WEEK**

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.**

Medicaid and/or Transportation Disadvantaged Recipient's

Signature: _____ Date: ____/____/____

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

RETURN COMPLETED FORM TO:

**Good Wheels, Inc.
Community Transportation Coordinator
10075 Bavaria Rd., SE
Fort Myers, FL 33913
1-239-768-2900
1-800-741-1570 (Toll Free)**

**Florida Relay System:
1-800-955-8770 - Voice
1-800-955-8771 - TTY**

ACCESSIBLE FORMATS ARE AVAILABLE UPON REQUEST