



LAKE COUNTY
FLORIDA

TRANSPORTATION DISADVANTAGED ELIGIBILITY APPLICATION

The Transportation Disadvantaged Program was established to provide transportation services to the elderly, disabled, economically disadvantaged, children at risk and to individuals who have no other forms of transportation. It is our goal to provide our citizens with safe, reliable, convenient, affordable and cost efficient public transportation. For more information, please call Lake County Connection at 352-326-2278.

Section 1 – Personal Information

Last Name _____ First Name _____ MI _____
Physical Address _____ City _____ Zip _____
Mailing Address _____ City _____ Zip _____
Subdivision Name _____ Home Telephone # _____
Work # _____ Cell # _____ E-mail Address _____
Medicaid # (if applicable) _____ Date of Birth _____
Sex _____ Social Security Number _____
Emergency Contact _____ Relationship _____
Home Telephone # _____ Work # _____ Cell # _____

Household Members

(please list each member and the back of form may be used if additional space is needed)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 2 – Availability of other Transportation

1. What type of vehicle do you own? Year _____ Make _____ Model _____ N/A
2. Is there a reason why you cannot drive your car? Yes / No If yes, can you tell us if it is Medical or because you are having vehicle troubles? Will the transportation services be temporary or permanent? (Please Indicate)
3. Does any other member of your household own a vehicle? Yes / No

4. Could anyone in your household, family or friends transport you to your appointments? Yes / No If no, please explain why? _____
5. How are you currently being transported to your appointments? _____
6. Are you aware that you are required to pay a co-payment for this program? Yes / No
(Please call Lake County Connection at 352-326-2278 for an explanation of the co-payment requirements).
7. Do you live in a facility that could provide transportation to you? Yes / No If yes, please provide the name of the facility _____
8. Are you enrolled in any other programs that will pay for or provide you with transportation services? Yes / No
If yes, please provide the name _____

Section 3 – Common Destinations

Please list all Hospitals, Doctors, Medical Facilities, Employment, Educational and other locations that you visit on a regular basis (please use the back of form if you need additional space).

<u>Hospital / Doctor / Facility</u>	<u>Address / Location</u>	<u>Monthly Visits</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section 4 – Special Needs

Please check or list any special needs you may require.

Manual Wheelchair _____ Powered Wheelchair _____ Powered Scooter _____ Walker _____ Cane _____
 Respirator _____ Service Animal _____ Personal Care Attendant (PCA) _____ Stretcher _____

Do you have any other needs / conditions that we need to be aware of in order to transport you safely? Yes / No. If yes, please explain: _____

Section 5 – Income and Expenses

Monthly Income:

Current Employer \$ _____ SSI \$ _____ Retirement Income \$ _____ Investment Income \$ _____
 Food Stamps \$ _____ Other \$ _____ Total Monthly Household Income \$ _____

Monthly Expenses:

Mortgage/Rent \$ _____ Utilities \$ _____ Vehicle Payment \$ _____ Groceries \$ _____
 Cable/Satellite \$ _____ Telephone \$ _____ Cell Phone \$ _____ Medical \$ _____
 Pharmacy \$ _____ Home Insurance \$ _____ Car Insurance \$ _____
 Fuel \$ _____ Other (please list) \$ _____

Total Monthly Household Expenses \$ _____

Section 6 – Certification and Acknowledgement

I understand and affirm that the information provided in this application for Non-Emergency Transportation Disadvantaged 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 eligible services as well as appointments. I understand that providing false or misleading information or making fraudulent claims or making false statements on behalf of others could constitute a felony under the laws of the State of Florida.

Lake County Board of County Commissioners and our Operator, MV Transportation, Inc. collects your social security number for the following purposes: Identification and verification; Billing and Payments; Benefit processing, and social security numbers are used as a unique numeric identifier and may be used for search purposes.

Applicant Signature _____ **Date** _____

Please make sure this form is filled entirely out and signed. An incomplete application will be rejected.

**Please mail this form to:
MV Transportation, Inc.
P.O. Box 491597
Leesburg, FL 34749-1597**

Please allow 7 business days to process your application. Please call Lake County Connection at 352-326-2278 to see if you qualify and to schedule transportation services.

The Transportation Disadvantaged Eligibility Application will be renewed on an annual basis.

OFFICE USE ONLY

Section 7 – Review Results

Date Received _____ New Eligibility Application _____ Redetermination _____

Reviewed By _____ Date Approved _____ Date Denied _____

Reason for Denial _____ Letter _____ Mode _____

Funding Source: Medicaid _____ (Y/N) TD _____ (Y/N) FDOT _____ (Y/N)