



**TRANSPORTATION DISADVANTAGED DETERMINATION FORM
HENDRY – GLADES COUNTIES**

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

SECTION I - IDENTIFYING INFORMATION

Medicaid card # : _____ Phone #: _____
Last Name: _____ First Name: _____
Home Street Address: _____ Apt. #: _____
Is this a: House Apartment Nursing Facility ACLF Boarding Home
City: _____ County: _____ Zip Code: _____
Date of Birth: ____/____/____ Your Current Age: _____ Male Female
Total Monthly Income: _____
Optional: White Black Hispanic Native American Asian Other _____
Are you a Student needing transportation to school? Yes No If yes please skip to Section V on back

SECTION II - NEED DETERMINATION

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</u>		<u>Does this person</u>	
	<u>Related to you</u>		<u>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 an 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 other places? Yes No
Can you travel on a LeeTran bus? Yes No
If NO, please explain why: _____
Would you use the LeeTran bus if you could ride free? 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 that apply)

- Blind/Legally Blind Wheelchair User Difficulty Walking
- Arthritis Cerebral Palsy Multiple Sclerosis
- Neuromuscular Disease Alzheimer's Disease Stroke
- 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, 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.**

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