TRANSPORTATION DISADVANTAGED ELIGIBILITY APPLICATION
WAKULLA COUNTY RESIDENTS

Florida Commission for the Transportation Disadvantaged (CTD)

Section 1

DETERMINATION OF ELIGIBILITY

Last Name _____ First Name _____ MI ____

Home Address _____ City _____State ____ Zip _____County:**WAKULLA**

Mailing Address_____City _____ State____Zip_____County:_____

DOB _____/_____/_____ Telephone (____) _____ TDD# (____)_____

Emergency Contact **(MUST HAVE)** _____ Relationship _____

Telephone (____) _____ Do you have any Cultural Considerations? _____

PLEASE CHECK ANY OF THE FOLLOWING MOBILITY AIDS OR EQUIPMENT YOU USE AND/OR IMPAIRMENTS YOU HAVE (CHECK ALL THAT APPLY):

☐ CANE ☐ CRUTCHES ☐ LEG BRACES ☐ WALKER ☐ OXYGEN

☐ SVC ANIMAL ☐ VISION IMPAIRED ☐ NEED LIFT SERVICE ☐ HEARING IMPAIRED

☐ NON-VERBAL ☐ WHEELCHAIR **(SEE SECTION 4)**

Section 2

IF YOU ARE A MEDICAID CLIENT AND REQUIRE TRANSPORTATION TO PURCHASE GROCERIES OR OTHER ACTIVITIES, OR YOU RECEIVE DISABILITY AND REQUIRE TRANSPORTATION FOR MEDICAL APPOINTMENTS AND TRANSPORTATION TO OTHER ACTIVITIES, PLEASE COMPLETE THE FOLLOWING:

Yes/No

1. _____ Do you own a car? If yes, provide model & year. Year _____Model_____
2. _____ Do you have a valid Florida Driver's License? If yes, what is the #? DL# _____
3. _____ Could you drive your car to medical appointments? **If not, why not (comment on line #3 PAGE 2)**
4. _____ Do any members of your household have a car? If so, can they transport you to medical appointments? **If not, why not (comment on line #4 PAGE 2)**
5. _____ Do you have family members in the county who can transport you?

CONTINUED

SECTION 2 CONTINUED

6. _____ Do you receive Medicaid? If so, please provide a copy of your Medicaid card.
7. _____ Can they transport you to medical appointments? **If not, why not (comment on line #6 PAGE 2)**
8. _____ Do you receive Disability? If so, please provide a copy of your eligibility letter.

COMMENTS:

3. _____

_____

4. _____

6. _____

Section 3

IF YOU HAVE NO OTHER MEANS OF TRANSPORTATION AND ARE AT LEAST 60 YEARS OF AGE, COMPLETE THE FOLLOWING:

1. _____ Have you used Wakulla Transportation in the past?
2. _____ Do you require the assistance of an escort or personal care attendant?
3. _____ Are you enrolled in any other programs that will pay for or provide transportation for Medical purposes?
   If yes, what is the name of the insurance company or program: _____
4. Please provide a copy of your Driver's License or Picture ID OR any other document(s) to validate your age.

Section 4

IF YOU HAVE A DISABILITY THAT REQUIRES A MOBILITY AID AND YOU HAVE NO OTHER MEANS OF TRANSPORTATION AVAILABLE, PLEASE COMPLETE THE FOLLOWING:

_____ Power Wheelchair (size: S, M, L, Extended) _____ Stretcher _____ Manual Wheelchair (size: S, M, L, Extended)

_____ Personal Care Attendant (PCA) or Family Escort necessary?
Other (Please explain):
_____

Section 5 Medical Professional Certificate

If you have a disability or medical condition that prevents you from driving or obtaining your own transportation, have this section completed by a physician, nurse practitioner, physical therapist or specialist who is familiar with your disability or medical condition.

Medical Professionals Name: _____

Office Address: _____

City, State, Zip Code: _____

Office Telephone Number _____

License/ Certification Number_____ State: _____

Profession:

- ☐ Physician
- ☐ Nurse Practitioner
- ☐ Physical Therapist
- ☐ Licensed Clinical Social Worker
- ☐ Certified Orientation and Mobility Specialist
- ☐ Other _____

Please explain in detail the reason the applicant is applying to ride with Wakulla Transportation.

If the applicant's condition is not permanent, please indicate the duration of the condition:

_____

_____ I certify that I have treated the applicant and I am familiar with their disability and/or health condition

Doctor's Signature: _____ Date: _____

Section 6

Certification and Acknowledgment

I understand and affirm that the information provided in this application for CTC Transportation Provider of services is true and correct, to the best of my knowledge, and will be kept confidential. I understand that providing false or misleading information, or making fraudulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida.

Applicant Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO

CTC NAME
Wakulla Transportation

CTC ADDRESS
Wakulla Senior Citizens Council, Inc./Wakulla Transportation
33 Michael Dr.
Crawfordville, FL 32327

CTC Telephone Number	CTC Fax Number	CTC TTD Number – 711
(850) 888-1016	(850) 926-8138	1-800-983-8495

Section 7

Results of Interview

DO NOT WRITE IN THIS SPACE – OFFICE USE ONLY

New Eligibility Application: _____ Y/N Update: _____ Y/N Date Received: ___/____/___ Reviewed by: _____

Approved Date: ___/___/____ Denied Date: ___/___/___ Reason for Denial: _____

Revised 06-2022