Marion Senior Services
MEALS • TRANSIT • IN-HOME SUPPORT


Florida Commission for the Transportation Disadvantaged

MARION TRANSIT
CLIENT INTAKE FORM

MARION TRANSIT SERVICE IS PROVIDED ACCORDING TO THE FOLLOWING NEEDS AS SPACE IS AVAILABLE:
MEDICAL • LIFE SUSTAINING ACTIVITIES • EDUCATION • WORK • BUSINESS • RECREATIONAL

SECTION I - DETERMINATION OF ELIGIBILITY

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ TELEPHONE #: (_____) _____ - _____ CELL #: (_____) _____ - _____

DOB: _____ /_____ /_____ SS#: _____ - _____ - _____

OTHER HOUSEHOLD MEMBERS (LIST EACH MEMBER)

NAME: _____ RELATIONSHIP: _____ AGE: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ AGE: _____ PHONE: _____

Transportation Disadvantaged (eligibility criteria) – Attach any documentation for eligibility claimed:

_____ Mental or Physical Disability _____ Poor* _____ Age**

(*Poor = Income level at or below 150% of the Federal Poverty Guideline / Age** = 60+ or <16 years old.)

SECTION II - AVAILABILITY OF TRANSPORTATION

YES / NO

1. _____ DO YOU OWN A CAR?
2. _____ DO YOU HAVE A VALID DRIVER'S LICENSE?
3. _____ COULD YOU DRIVE YOUR CAR TO MEDICAL APPTS? IF NOT, WHY? _____
4. _____ DOES ANYONE IN YOUR HOUSEHOLD HAVE A CAR?
5. _____ COULD THEY DRIVE YOU TO YOUR APPOINTMENTS? IF NOT, WHY? _____
6. _____ DO YOU HAVE FAMILY MEMBERS WHO CAN TRANSPORT YOU TO APPOINTMENTS?
7. _____ DO YOU HAVE FRIENDS WHO CAN TRANSPORT YOU TO YOUR APPOINTMENTS?

LIST ALL HOSPITALS, DOCTORS, AND MEDICAL FACILITIES THAT YOU VISIT ON A REGULAR BASIS:

NAME OF HOSPITAL/DOCTOR/FACILITIES:	TYPE OF TREATMENT?	# MONTHLY VISITS?

SECTION III -

YES / NO

1. _____ DO YOU LIVE ON A **SUNTRAN** ROUTE? WHAT IS THE DISTANCE TO THE NEAREST BUS STOP? _____
2. _____ DO YOU HAVE ANY LIMITATIONS THAT WOULD PREVENT YOU FROM RIDING THE BUS?
   PLEASE DESCRIBE: _____
3. _____ ARE YOU ENROLLED IN ANY OTHER PROGRAM(S) THAT WILL PAY FOR OR PROVIDE TRANSPORTATION?
   PLEASE LIST: _____

SECTION IV -

PLEASE CHECK OR LIST ANY SPECIAL NEEDS, SERVICES OR MODES OF TRANSPORTATION YOU REQUIRE DURING TRANSPORTATION:

WHEELCHAIR ______, POWER WHEELCHAIR ______, CANE______, WALKER ______, SERVICE ANIMAL ______, OXYGEN ______

PERSONAL CARE ATTENDANT ________, LIFT TO LOAD ________, SCOOTER ________

OTHER: ____

SECTION V -

I ATTEST ALL INFORMATION IS CORRECT TO MY KNOWLEDGE AND ANY CHANGES WILL BE REPORTED TO MARION TRANSIT IMMEDIATELY:

SIGNATURE OF APPLICANT: ______________________ DATE: ______ / ______ / ______

SIGNATURE OF PREPARER: ______________________ DATE: ______ / ______ / ______
(*IF OTHER THAN APPLICANT*)

PREPARER – PRINT NAME: ______________________ RELATIONSHIP OR MARION TRANSIT: ______________

OFFICE USE ONLY

LAST NAME: ______________________ FIRST NAME: ______________________

SECTION VI -

AUTHORIZATION

APPROVAL DATE: ______ / ______ / ______

DENIED DATE: ______ / ______ / ______ REASON: ______________________

MANAGER REVIEW – IF DENIED

BY : ______________ TITLE: ______________ DATE: ______ / ______ / ______

COMMENTS: ____

+++ END +++