Good Wheels
Transportation for the Disabled and Disadvantaged

TRANSPORTATION DISADVANTAGED DETERMINATION FORM

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:

Name	Is this person Related to you			Does this person Own a car	
_____	□ Yes	□ No	___/___/___	□ Yes	□ No
_____	□ Yes	□ No	___/___/___	□ Yes	□ No
_____	□ Yes	□ No	___/___/___	□ Yes	□ No
_____	□ Yes	□ No	___/___/___	□ Yes	□ 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 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
Have you ever taken the LeeTran bus to the doctor or 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
□ Muscular Dystrophy □ Mentally Challenged □ Emotionally Challenged
□ Other (describe) _____

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**.

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