**NASSAU COUNTY COUNCIL ON AGING, INC.**

NassauTRANSIT provides transportation service by appointment for Nassau County residents who are

elderly, disabled, economically disadvantaged or children at risk and have limited transportation options.

For more information, please call NassauTRANSIT Customer Service at 904-261-0700 or 800-298-9122.

***Section 1 – Member Information***

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (If Different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No. (**SEE SECTION 5 ON BACK**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid No. (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Caregiver \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Members/Dependents who may be eligible for transportation (attach additional page if needed):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | **Date of Birth** |  | **Social Security No.** |  | **Relationship** |
|  |  |  |  |
|  |  |  |  |

***Section 2 – Access to Transportation (the State of Florida requires that we have the following information before we can provide you with service):***

1. What type of vehicle do you own? Year \_\_\_\_\_\_\_\_\_ Make\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model \_\_\_\_\_\_\_\_\_\_\_\_\_\_ None \_\_\_\_\_\_\_
2. Is there a reason why you cannot drive your car? Yes / No If yes, please explain why.
3. Is your need for transportation services temporary or permanent? (Please indicate.)
4. Does another member of your household own a vehicle? Yes / No
5. Can anyone in your household, family or friends transport you to your appointments? Yes / No If no, why not?
6. How are you currently being transported to your appointments?
7. Do you live in a facility that can provide transportation? Yes / No If yes, please provide the name of the facility.
8. Are you enrolled in a program that will pay for, or provide you with, transportation? Yes / No If yes, please provide the name of the program.

***Section 3 – Frequent 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).

***Section 4 – Mobility Devices/Special Needs*** Please check all that you may require.

Wheelchair \_\_\_\_\_\_\_ Powered Wheelchair/Scooter \_\_\_\_\_\_\_ Walker \_\_\_\_\_\_\_ Cane\_\_\_\_\_\_\_

Service Animal\* \_\_\_\_\_\_\_ Personal Care Attendant\*\_\_\_\_\_\_\_

\*Please refer to the enclosed Terms and Conditions of Service regarding Service Animals and Personal Care Attendants.

Do you have any other needs or conditions (cultural, religious, physical, psychological, etc.) we should be aware of in order to transport you safely? Yes / No If yes, please explain:

***Section 5 – Certification and Affirmation:* I affirm that the information provided in this application is true and correct to the best of my knowledge. I understand that it will be kept confidential and shared only with medical and transportation professionals in evaluating my eligibility for the Registered Customer program. I understand that providing false or misleading information, or making fraudulent claims or false statements on behalf of others could void my registration in the program. I have received, read and understand the attached “Notice of Privacy Practices” and “Terms and Conditions of Service”. I understand that Nassau County Council on Aging, Inc. collects my personal information, INCLUDING MY SOCIAL SECURITY NUMBER, for purposes of identification and eligibility verification only.**

**Applicant Signature (required)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caregiver Signature (if applicable)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE THE ATTACHED “RECEIPT FOR NOTICE OF PRIVACY PRACTICES” AND RETURN IT WITH THIS FORM. WITHOUT IT, THIS APPLICATION IS INCOMPLETE AND WILL NOT BE PROCESSED.**

***Please mail this form*** AND ***the attached “Receipt for Notice of Privacy Practices” to:***

NassauTRANSIT

102 N 13th ST

FERNANDINA BEACH, FL 32034

**Please allow us 3 business days to process your completed Application (BOTH FORMS) after we receive them.**

**After 3 business days please call 904-261-0700 or 800-298-9122 to see if you qualify and to schedule transportation.**

***This Registered Customer application may be reviewed annually to determine continued eligibility.***

***!!! THANK YOU !!!***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

REVIEW RESULTS:

Initial Receipt \_\_\_\_\_\_\_\_\_\_\_\_ Docs Completed \_\_\_\_\_\_\_\_\_\_\_ Approved \_\_\_\_\_\_\_\_\_\_ CSR \_\_\_\_\_\_\_\_\_\_ TD \_\_\_\_\_\_\_\_\_\_\_\_

**BASIS(ES): E** \_\_\_\_\_ **D** \_\_\_\_\_ **I** \_\_\_\_\_ **C@R** \_\_\_\_\_ **CUSTOMER NO.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 09/2024 S:\Administration\Forms\TD Forms\TD Application – Part 1 – Member Application