TRANSPORTATION INFORMATION

PLEASE READ, SIGN, DATE AND RETURN

PURPOSE: **Strictly limited to medical appointments**
- Transportation to GCDJFS is **NOT** available.

ELIGIBILITY: **Generally, Medicaid recipients who don't have cars.**
- Persons over 60, pregnant women on public assistance, and clients pursuing SSI are eligible in separate categories.

ACCESS: **You MUST sign up at GCDJFS before you ride.**
- Sign up lasts six months; notice to renew is mailed.
- You **MUST** renew to continue with transportation.

PROCEDURE: **SAME DAY CALL - NO GO - NO EXCEPTIONS**
- **The client is to call *SEAT* at (740) 439-3393 with appointments.**
- The client may check back with *SEAT* about arrangements.
- Please give *SEAT* as much notice as possible (at least a 48-hour notice).
- This is a first call, first serve program and if you do not call soon enough, you may not get a ride on the day you need it.
- Please give *SEAT* as much information as you can when you call (day and time of your appointment; name and address of where you are going).
- The client is to call if anything changes.
- The client is to call *SEAT* and GCJFS if you move and have an address change.
- Please call *SEAT* if your appointment has been cancelled or if you decide not to go.
- Anytime you are having any kind of surgery, **PLEASE** take a family member or friend with you. Please do not make our drivers responsible.

ETIQUETTE:
- If you have other resources, please use them.
- Remember, the drivers are private citizens in private cars; please cooperate with them in the use of their cars and their time.
- Please do not ask the drivers to take you any place that is not medically related. They are not permitted to do this.
- If you become a chronic **NO SHOW** (a driver comes out to pick you up and you have not cancelled the ride or you decide not to go) or create a reluctance among the drivers to deal with you, **you may be denied transportation privileges for at least six months.**
- If you incur two (2) no shows within one month, you may not be eligible for additional transportation service for one month, beginning the first day of the next calendar month. The second occurrence of two (2) no shows in a month may result in a two (2) month suspension, beginning the first day of the next calendar month. The third occurrence of the same offense may result in a six (6) month suspension of transportation services, beginning the first day of the next calendar month.

I have read and understand the above information.

Signature of Applicant ____ Date ___________________

Signature of Eligibility Determiner _________________________________ Date ___________________

Guernsey County Department of Job & Family Services
740) 432-2381, ext. 2217 or 1-800-307-8422, ext. 2217

South East Area Transit (*SEAT*)
(740) 439-3393

Trans 100 (4/1/10)

REQUEST FOR TRANSPORTATION

☐ Medicaid ☐ Disability Determination ☐ PRS ☐ APS

__X__ Initial Request

Name ________________ Case Number ________________

Address ________________ City ________________ **OH** State ________________ Zip Code **GUERNSEY** County

Social Security Number ________________ Date of Birth ________________ Telephone Number ________________ # in Family ________________

Consumer Name	Recipient #	Code
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

This request must be signed by applicant or one acting responsibly in behalf of the applicant. The date of the applicant's signature must be entered.

By my signature below, I certify that the information given on this application is correct and I agree to promptly report any changes in the information. I give consent for the agency to make whatever contacts are necessary to provide and document services.

HIPAA standards prohibit the exchange of information with other agencies and professionals concerning an individual without the written permission of the individual involved. Permission is granted by this release for the GCDJFS to exchange information whereas they see fit relevant to my transportation service.

Note: You have the right to request a County Conference if you are not in agreement with any action, or lack of action, on the part of the agency. You must report within ten days any change.

Signature of Applicant ________________ Date ________________

☐ Informed Client of Managed Care Transportation Program _______ (initials)

Signature of Eligibility Determiner ________________ **Guernsey Co Dept Job & Family Services** Name of Agency

Date Request Received ________________ ___ Approved ____ Denied ________________ Date of Action

TRANS 107 (12/30/09)