



Non-Emergency Transportation Application

Complete the application below.

☰ ACDJFS Social Services, 951 Commerce Pkwy., Lima, OH 45804

☎ FAX: 419.228.0420 ✉ allen_social_services@jfs.ohio.gov Questions? Call 419.999.0224

Applicant Name (First Name, Middle Initial, Last Name)		Assistance Group Number	Medicaid ID #
Address (Number Street/Apt Number)			City/State/Zip
Phone Number	Email Address		Social Security Number

Do you live on a bus route? Yes No
 Vehicle in the household? Yes No If yes, is the vehicle insured? Yes No
 Is the vehicle in running condition? Yes No
 Do you have a valid driver's license? Yes No
 Does anyone in your household have a valid driver's license? Yes No

List Household Member Name(s)	Relationship to Applicant	Birth date	SS#	Income/Source	How Often Paid	Monthly Gross Salary*	Date Verified
1	SELF						
2							
3							
4							
5							
6							

AGENCY USE: TITLE XX: 185% FPG for AG: \$	TOTAL MONTHLY INCOME:	\$	
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I _____ have received \$ _____ in the past 30 days and will receive \$ _____ in the next 30 days.

 Client Signature Date

I _____, an adult age 18 or older or parent/guardian of applicant, agree to have the staff of agencies and medical providers working with me exchange and disclose information on me in order to make determinations of my eligibility for benefits and to provide services to the extent that such disclosure is permitted by state and federal law and necessary for administration of the programs. By my signature below I affirm to the best of my knowledge and belief these answers are complete and correct. I understand the law provides penalty of fine or imprisonment for anyone convicted of accepting assistance for which not eligible. I state under penalties of perjury that all the information on this application is true and correct to the best of my knowledge. I also acknowledge that I have received a copy of my rights regarding privacy, fraudulent assistance, and voter registration.

Applicant Signature **Date**

ACJFS Caseworker Signature **Date**

JFS USE ONLY: INDIVIDUAL SERVICE PLAN AUTHORIZATION						
Service Name	Service Type	Code/Fund Source	Date of Service		Authorized Recipients	Vendor/Provider By
			Begin	End		