PASCO COUNTY PUBLIC TRANSPORTATION (PCPT)

MEDICAID BUS PASS APPLICATION

8620 Galen Wilson Boulevard
Port Richey, Florida 34668
(727) 834-3322
FAX (727) 859-0589

Medicaid bus passes are issued to Medicaid eligible recipients who have no other means of transportations to and from necessary medical appointments. The doctors **MUST** be Medicaid providers and provide Medicaid compensable services.

You'll also enjoy more flexibility in making medical appointments and more mobility in your everyday life as the pass allows you trips on PCPT Transit System.

Your monthly bus passes will be forwarded to you via mail. Please fill out this form in its entirely, otherwise we cannot process the bus pass application.

Mr./ Mrs./ Ms. First Name Middle Initial Last Name Social Security #

Street Address Apt #

City State County Zip

Name of Condo/Apartment, Sub-Division or Mobile Home Park

Closest Major Intersection

Telephone (home) (work) Date of Birth Sex (M) (F)

*The information below is optional and is used for statistical reporting purposes only. It is not used to determine eligibility for service.

*Race/Ethnicity: American Indian_____ Asian or Pacific Indian_____ Black, Not Hispanic Origin_____ Hispanic_____ White, Not Hispanic Origin_____

*Household Yearly Income * Source of Income *Number in Household

*Marital Status Medicaid # (10 digits) Medicaid Gold Card # (8 digits)

Other Household Members Name Relationship Age Driv. Lic.(Y/N) Type of Vehicle
(Please list each member)

Do you own a vehicle? Yes____ No ____ Do you have a Driver's License? Yes ____ No____
Type of vehicle (car/van, etc) _____ Does any member of your household own a vehicle? Yes____ No ____
Do you have friends or family members in the County who can transport you? Yes____ No____ If not, why?

Please list all Hospitals, Doctors and Medical Facilities that you visit on a regular basis:

NAME OF DOCTOR OR FACILITY	**ADDRESS**	**TYPE OF TREATMENT**	**# OF VISITS PER MONTH**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: If someone other than the applicant has completed this form please provide the appropriate information in the space below.

_____

Name Relationship to Applicant

_____

Address City State Zip

_____

Daytime Telephone

_____

This information is available in an accessible format upon request. To request these formats, please contact PCPT.

I understand and affirm that the information provided in this application is truthful and accurate to the best of my knowledge. I understand that providing false or misleading information, or making fraudulent claims, or making false statements on behalf of others constitutes a felony under the laws of the State of Florida. I agree to notify the *PCPT* office of any changes in my status immediately and understand that this may affect my eligibility to use these services.

Applicant's Signature _____ Date _____