Nassau TRANSIT
Powered by Nassau County Council on Aging

PLEASE COMPLETE THE ATTACHED

"REGISTERED CUSTOMER PROGRAM APPLICATION"

AND

"RECEIPT FOR NOTICE OF PRIVACY PRACTICES"

MAIL BOTH FORMS 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 us at
904-261-0700 or 800-298-9122
to confirm your service eligibility.

The Registered Customer Program Application may be reviewed annually to determine continued eligibility.

THANK YOU!

NASSAU COUNTY COUNCIL ON AGING, INC.

PART 1 OF 3

REGISTERED CUSTOMER PROGRAM APPLICATION

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. _____

PLEASE SIGN AND RETURN THIS FORM.

WITHOUT IT, THE APPLICATION IS INCOMPLETE.

NASSAU COUNTY COUNCIL ON AGING, INC.

REGISTERED CUSTOMER PROGRAM APPLICATION

PART 2 OF 3

RECEIPT / ACKNOWLEDGMENT FOR "NOTICE OF PRIVACY PRACTICES"

As part of my Registered Customer Program Application, I have received and understand the "***Notice of Privacy Practices***" published by Nassau County Council on Aging, Inc.

_____

Applicant Name (please print)

_____ _____

Applicant Signature Date

_____

Caregiver Name (if applicable) (please print)

_____ _____

Caregiver Signature Date

NASSAU COUNTY Council on Aging

SENIORS LIVING HAPPY, HEALTHY LIVES

REVIEW THIS DOCUMENT CAREFULLY
AND
KEEP FOR YOUR RECORDS

NASSAU COUNTY COUNCIL ON AGING, INC.
TRANSPORTATION PROGRAM MEMBERSHIP APPLICATION
PART 3 OF 3

NOTICE OF PRIVACY PRACTICES

(HIPAA - Health Insurance Portability and Accountability Act)

Effective April 14, 2003

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, volunteers, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and service you receive from the department in your personal file.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

A. **HOW WE MAY DISCLOSE INFORMATION ABOUT YOU**

1. For Treatment: We may disclose information about you to provide you with medical treatment or services. We may disclose health information about you to other personnel who are involved in taking care of you and your health.
2. For Payment: We may use and disclose health information in order to bill and collect payment for health care services.
3. Health Care Operations: We may use and disclose health information about you to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.
4. Other Permitted Uses and Disclosures: There are a number of other specific ways that we may disclose health information about you without permission for the following purposes, subject to legal requirements and limitations, such as: **To Avoid Serious Threat to Health Safety; Required by Law; Research; Organ Tissue Donation; Military Veterans; National Security and Intelligence; Workers Compensation; Public Health Risk; Health Oversight Activities; Lawsuits and Disputes; Law Enforcement; Coroner; Medical Examiners and Funeral Directors; Volunteers and Information Not Personally Identifiable.**

B. **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you.

1. Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records that we use to make decisions about your care. You must submit a written request to the Compliance Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
2. Right to Amend: If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction form to the Compliance Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    a. We did not create unless the person or entity that created the information is no longer available to make the amendment.
    b. Is not part of the health information that we keep.
    c. You would not be permitted to inspect and/or copy.
    d. Is accurate and complete.
3. Right to Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Compliance Officer. It must state a time period which may not be longer than six (6) years and may not include dates before **April 14, 2007**. Your request should indicate in what form you want the list (e.g. on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
4. Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations.
5. We Are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

C. **CHANGES TO THIS NOTICE**

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

D. **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for purposes other than those identified in the previous section without your specific written authorization. We must obtain your authorization separate from any consent we may have obtained from you. If you give us authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses of disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed written authorization (different from the authorization and consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health operations we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

Contact Information: Don Harley, Human Resources and Compliance Director
Nassau County Council on Aging, Inc.
1901 Island Walk Way
Fernandina Beach, FL 32034
(904) 261-0701
donharley@nassaucountycoa.org