

New Jersey Department of Human Services
Division of Aging Services
Provider Application Section III: Services

TRANSPORTATION SERVICES

*Read carefully the description of services and requirements.
If you do not qualify, please do not apply.*

Definition:

Service offered in order to enable individuals to gain access to other community services, activities and resources specified in the plan of care. Transportation services under the program shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

Service Limitations/Exclusions Include:

- Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.
- Services are limited to those, which are required for implementation of the plan of care (POC).
- Transportation incidental to the provision of another service is not reimbursable.

Billing Codes:

<u>JACC</u>	<u>Service/Unit</u>
J9834	1 – 1-way trip per mile
J9835	1 – 1-way trip expenses

TRANSPORTATION SERVICES PROVIDER QUALIFICATIONS

The applicant must submit evidence that it meets **all** items within the following section(s).

Please check off **ONE** section in which you are applying
Section 1

Section 1

- 1.a Evidence of Liability Insurance and Worker’s Compensation Coverage
- 1.b Description of vehicles used in service and copies of any required licenses
- 1.c Business entity with evidence of authority to conduct such business in NJ, i.e. NJ Tax Certificate, Trade Name Registration and/or Ownership proof*
- 1.d Fee Schedule

*Submit photocopy as evidence.

**Check all evidence submitted with application.
Incomplete applications and / or applications submitted without required
documentation and evidence will be returned.**

CERTIFICATION

FOR THE PURPOSE OF ESTABLISHING ELIGIBILITY TO RECEIVE DIRECT PAYMENT FOR SERVICES TO RECIPIENTS UNDER THE NEW JERSEY JACC PROGRAM, I CERTIFY THAT THE INFORMATION FURNISHED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE. I AM AWARE THAT IF ANY OF THE STATEMENTS MADE BY ME IN THIS APPLICATION ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO DISQUALIFICATION FROM THE NEW JERSEY JACC PROGRAM. I AGREE TO NOTIFY THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING SERVICES OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.

Name and Title of Applicant
Representative_____

Signature_____ Date_____