Ryan White Program
Service Delivery Guidelines
Fiscal Year 2019
(Year 29)

Section XV –
Medical Transportation
Acknowledgment

Miami-Dade County
Office of Management and Budget
Grants Coordination

Miami-Dade County Ryan White Part A Program
Acknowledgement to Receive Monthly Transportation Assistance
(required for <u>each</u> monthly discounted EASY Ticket dispensed)

Month and Year of Service: _____

By my signature below, I certify that *(all items below must be checked to receive assistance)*:

☐ I am **<u>not eligible</u>** to receive transportation assistance (including, but not limited to, Medicaid non-emergency medical transportation, STS, discounted EASY Ticket, etc.) **this month** from any source other than the Miami-Dade County Ryan White Part A Program. Other sources include, but are not limited to: Medicaid, Medicaid Managed Medical Assistance (MMA), Medicaid Long Term Care (LTC), and the County's Golden Passport or Transportation Disadvantaged Program.

☐ I have scheduled **<u>and</u>** will attend at least three (3) medical and/or social service appointments for the month I will use this discounted EASY Ticket. *(Proof is required; e.g., appointment card, etc.)*

☐ I understand that authorized persons from the Miami-Dade County Ryan White Program and the Department of Transportation and Public Works will conduct regular reconciliation reviews of clients receiving discounted transportation assistance; **<u>and</u>** I consent to this review for the purpose of ensuring program integrity.

☐ I understand that if the results of this review indicate I received more than one instance of free, discounted, or reduced fare transportation assistance (for example: STS, discounted EASY Ticket, etc.) for any month during the review, I will no longer be able to receive this assistance from the County.

☐ I will not share this EASY Ticket with anyone **<u>and</u>** I will not sell it; or I will risk losing this assistance.

This form has been clearly explained to me in my preferred language, as indicated *(check one)*:
☐ English ☐ Spanish ☐ Creole ☐ Other (specify: _____)

Client Name	
Client Signature	
CIS#	
Date	

Part A Subrecipient Representative:

Name of Staff Dispensing Transportation Voucher	
Staff Title	
Agency Name	
Staff Signature	
Date	