

**APPLICATION FOR NON-EMERGENCY TRANSPORTATION**  
**(NET) ROSS GO/TRANSIT ID**

Do you currently have a Ross Go/Transit ID? Yes \_\_\_\_\_ No \_\_\_\_\_

NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ Date of Birth \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_ No. of Minor Children \_\_\_\_\_

**The information below MUST be complete in order to be approved for a ROSS GO ID/TRANSIT ID**

ARE YOU REQUESTING THIS ID FOR MEDICAL TRIPS? Yes \_\_\_\_\_ No \_\_\_\_\_

I'm requesting trips for:  January-March  April-June  July-September  October-December

I will be attending 3 appointments per quarter.

Date of first appointment: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Location of appointment: \_\_\_\_\_

**I understand that if I do not turn in the Medicaid Verification Form for three medical appointments per quarter, I will not receive a bus pass for one year.**

I understand that this will be my transportation for medical appointments for the quarter.

I understand that I am responsible for transit fees for all other trips.

I understand that using this pass for anyone other than my children or myself can result in the loss of NET transportation benefits through SCOJFS.

I will submit my medical verification to Chillicothe Transit System - 575 E. 7<sup>th</sup> St. Chillicothe, Oh

I understand that if my ID is lost, stolen or destroyed for any reason, I will be responsible for a \$5.00 replacement fee.

I have read and understand the above information and by signing below agree to the terms. I understand that this bus pass is only good through the end of the quarter.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Date rcv'd: \_\_\_\_\_ Date approved: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ Pass#: \_\_\_\_\_