Name: _____ Date: _____

APPLICATION FOR TRIP-LINK PROGRAM

The information obtained in this application will be used to determine eligibility for the Transportation Reimbursement Intercommunity Program (TRIP-LINK) and will not be provided to any other person or agency without prior written approval of the applicant.

To apply for eligibility:

1. The "Rider" is the "Applicant."

> **All completed information MUST BE ABOUT the applicant's"condition and lifestyle.**

   a. **The "Applicant'" must fully complete the application form.**
   b. **The "Applicant's" Legal Representative or Guardian may complete for the "Applicant."**
   c. **If "Applicant" has a Legal Representative or Guardian, legal documentation showing Guardianship must be attached to this application.**

2. Your detailed responses and explanations will help us to determine if you are eligible for the program. Please respond to ALL questions or your application will be considered incomplete. ***Incomplete applications will be returned and will not be processed.***

3. Applicant must provide a SIGNATURE on the last page of the application. If there is no signature on the last page the application is not valid and will be returned to you.

   a. The Applicant's" Legal Representative or Guardian may sign the application for the Rider.

> **If Applicant has a Legal Representative or Guardian, legal documentation showing Guardianship must be attached to this application.**

4. Applicant may be required to send other documents that will help us understand abilities. All information provided will be kept strictly confidential.

5. The TRIP-LINK eligibility specialist and/or committee will review the completed application and will either approve or deny eligibility. Prior to coming to a determination we may request more information from you.

6. If application is approved by the TRIP-LINK committee, a packet will be mailed containing details of documents that will be required to be provided to the TranCare **before mileage reimbursement will begin.**

SUBMIT COMPLETED APPLICATION BY MAIL, FAX OR EMAIL TO:

TRIP-LINK , 300 S. Columbia St., First Floor, Wenatchee, WA 98801
Fax: 888-990-7026 Email: triplink@trancarerides.org

Name: _____ Date: _____

TRIP-LINK APPLICATION Date:_____

Applicant (FIRST name_____

Applicant: (LAST name _____

PLEASE PRINT

How did you hear about TRIP-Link?

_____

_____

Home Address of Applicant:

Name of Housing Complex (if applicable):

Street: _____ Unit # : _____

City:_____ Zip Code: _____

Mailing Address of Applicant (If different from Home Address):

Street or PO Box: _____ Unit # : _____

City:_____ Zip Code: _____

Primary/Preferred Phone: (____)_____Other Phone: (___)_____

Email address of Applicant: _____

Date of Birth : ____/____/____ Gender assigned at birth: ☐ Female ☐ Male

Primary Language of Applicant: ☐ English ☐Spanish ☐ Other (Specify): _____

Do you require the assistance of an interpreter if primary language is other than English? _____

Applicant please answer: <u>Who do you live with</u>?

- ❑ Live alone
- ❑ With paid caregiver
- ❑ With spouse
- ❑ In skilled nursing facility
- ❑ With other family members
- ❑ In assisted living facility/adult family home
- ❑ With friends
- ❑ Other _____

Emergency Contact for Applicant: _____

Name & Phone # (someone *other* than your volunteer driver)

Relationship to Applicant: _____

Name: _____ Date: _____

Relationship to Applicant: _____

Primary/Preferred Phone: (____)_____ Other Phone: (____)_____

Email address: _____

Name: _____ Date: _____

Are you employed? ☐ Yes ☐ No
If yes, what is your work phone number? _____

Are you a Veteran? ☐ Yes ☐ No

Living arrangements:

Who do you live with? ☐ Live Alone ☐ with paid caregiver ☐ with spouse ☐ with friends
☐ in skilled nursing home ☐ with other family members ☐ in assisted living facility/adult family home
☐ Other _____

Do you have an in home support caregiver?

☐ Yes ☐ No If yes, are they approved to drive/provide trips for you? ☐ Yes ☐ No

Does a family member drive you to places you need to go to? ☐ Yes ☐ No
If yes, does this family member live with you? ☐ Yes ☐ No
How close does your nearest family member live? _____
Does a family member drive you to places you need to go? ☐ Yes ☐ No
If yes, does this family member live with you? ☐ Yes ☐ No

Your disability / health-related conditions:
Specific answers to the questions will help us in determining your eligibility.

Are you disabled in any way? ☐ Yes ☐ No
If yes, your health conditions are: ☐ Permanent ☐ Temporary

Are your health conditions verified by a doctor?
☐ Yes ☐ No If yes, when were they verified? _____
Month/Year
Are you able to drive a vehicle owned by you?
☐ I don't own a vehicle ☐ Yes ☐ No

If yes, what are your limitations or restrictions?
_____
_____

Are you registered with any alternative transportation or special transportation services for individuals with disabilities (such as People for People, Link Plus, Link Transit DART)? ☐ Yes ☐ No

If yes, please list the name of the agency and address below: (See attachment A for list of potential service agencies)

_____
_____
_____
_____

Are you able to use public transportation (buses) or special transportation services individuals with disabilities (such as Link Plus or DART)? □

□ Yes □ No □ Transportation is not available where I live

Are you physically / mentally able to stand to wait for public transportation? □ Yes □ No

Briefly explain health-related conditions/limitations/disabilities that prevent you from using public transportation (buses) or special transportation services for individuals with disabilities (such as Link Plus, People for People) either some or all of the time:

_____

_____

_____

_____

How does your health conditions effect your monthly travel?

_____

_____

_____

Please indicate any mobility aids you regularly use:

□ Cane □ Walker □ Wheelchair □ Other

Is your mobility aid oversized? □ Yes □ No

In the last month, how many times did you see and spend time with your family (this is to determine isolation):

□ Daily □ Once a week □ Once every two weeks □ Once a month

□ Never □ Other

How have you been able to currently meet your transportation needs?

_____

Have you recently missed any medical appointments due to lack of transportation? □ Yes □ No

Please list and explain your disabilities that you feel would qualify you for the program:

_____
_____
_____
_____
_____

How do you think TRIP-Link will meet your needs?

_____
_____
_____

Have you identified a potential Volunteer Driver if you are approved to participate in the program?

☐ Yes ☐ No

If Yes, what is your relationship to the Volunteer Driver:

☐ Friend ☐ Neighbor ☐ Caregiver ☐ Relative

Optional: The following information assists us with our funding resources:

Your ethnicity:

□ Not Hispanic or Latino □ Hispanic or Latino □ Decline to state

Your race:

□ White □ African-American or Black □ American Indian or Alaskan Native
□ Asian □ Pacific Islander □ Decline to state □ Other _____

What is your monthly income?

□ $957 or less □ $958 - $1,148 □ $1,149 - $1,291 □ $1,292 or more

Applicant:

The following information assists us in determining the number of miles you may be awarded monthly to support your transportation needs:

Applicant please answer:

MEDICAL TRIPS: List the types (*examples: primary care, physical therapy, dentist, pharmacy, etc.),* addresses (*include the CITY*), and how often you need to travel:

Type: (Example) Dentist How Often: Twice a year

Address: 1234 Main Street, Main Town, WA 00009

Type: _____ How Often: _____

Address: _____

Type: _____ How Often: _____

Address: _____

Type: _____ How Often: _____

Address: _____

Type: _____ How Often: _____

Address: _____

Type: _____ How Often: _____

Address: _____

What **other** purposes and destinations would you like to travel to and how often?

Banking Bank Name: _____ How Often: _____

Address: _____

Religious: _____ How Often: _____

Address: _____

(Cont.) What other purposes and destinations would you like to travel to and how often?

Shopping Store: _____ How Often: _____

Address: _____

Shopping Store: _____How Often: _____

Address: _____

Other: _____How Often:_____

Address: _____

Other: _____ How Often: _____

Address: _____

Other: _____How Often: _____

Address: _____

Other: _____How Often:_____

Address: _____

OFFICE USE ONLY:
Information taken by: Name: _____ Office Location: _____

Transportation Reimbursement Intercommunity Program
Application Certification and Hold Harmless Form

I have reviewed my application to participate in the TRIP-Link and certify that it is true and accurate to the best of my knowledge. I understand Trip Link staff will follow up with me to acquire any additional information needed to process my application.

I understand that the information I am providing will be treated as confidential, will only be utilized to determine my initial and continuing eligibility for the program, and will be retained as a permanent part of my service file. I authorize representatives of Trip Link to contact persons whom I have named or to make other inquiries as necessary to verify the information that I have provided.

I understand that it may be necessary to contact a professional familiar with my functional abilities to determine my eligibility for this program. I also understand that the TRIP-Link staff may be verifying information provided in this application (such as in home care participation).

I understand that it is the policy of Trancare and Trip Link to pursue any alleged or suspected instances of fraud. A "fraudulent claim" is committed when a false representation of a present or past fact is made by a consumer, member of his/her family, or unrelated person such as their caregiver or volunteer driver, which results in the release of funds.

I agree to abide by all the Trip Link policies, as communicated to me, including policies in the TRIP-Link handbook, and I acknowledge that my failure to abide by any TRIP-LINK policies may result in the termination of services.

I acknowledge that being driven by others is an inherently dangerous activity and that my participation in this program could involve some danger to my person or property, or the person or property of others. In consideration of my participation in the TRIP-Link, I agree to indemnify and hold harmless Trancare, Trip Link, its officers, directors, agents, employees, and volunteers, as well as any and all organizations, agencies or individuals who provide funding to or otherwise support the TRIP-LINK, from any and all claims, losses, and liabilities (including costs and attorney's fees) for damage to property or injury or death to myself or others arising out of or in any way connected with my participation in the program.

Applicant:

_____ SIGNATURE: _____ Date: _____
PRINT NAME

(If unable to sign, please mark an X. See witness identification below. *)
If there is no signature the application is not valid and will be returned to you.

If a Legal Representative or Guardian, the **Legal Representative or Guardian:**

_____ SIGNATURE: _____ Date: _____
PRINT NAME

What is your relationship to the applicant?

❑ POWER OF ATTORNEY ❑ GUARDIAN:
(Copy of legal document required)

*If Applicant (Rider) is unable to sign, the Interpreter or Witness must print and sign here:

_____ SIGNATURE: _____ Date: _____
PRINT NAME

ATTACHMENT A:

People for People, non-emergent medical transportation

Yakima, WA

Leavenworth Dial A Ride
2700 Euclid Avenue
Wenatchee, WA 98801

Chelan Dial A Ride
2700 Euclid Avenue
Wenatchee, WA 98801

Agency In Home Care services:

ResCare

Beneficial

Serengeti

Visiting Angels

Aging & Adult Care of Central WA