LinkPlus

Checklist & Eligibility Application

Thank you for your interest in LinkPlus, Link Transit paratransit service.

If you are seeking eligibility for services, you must complete the entire application process required by the Americans with Disabilities Act, including

1. The Application form (extra documentation is required if someone other than applicant signs the form, listed on the next page)
2. The enclosed Informed Consent/Professional Verification Release form
3. A telephone interview assessment.

If you have questions or need assistance completing the application form, please call 509-662-1155.

CHECKLIST & INSTRUCTIONS

All pages of the completed application must be returned at the same time. Before submitting the application form, please:

- ❑ Read the LinkPlus pamphlet included with the application form.
- ❑ Complete pages 1-7 of the application.
- ❑ Ensure the application form is signed on Page 6 by the Applicant. Please print clearly.
  - If you are under 18, your parent or Legal Guardian* is required to sign the application
- ❑ Ensure the "Informed Consent/Professional Verification Release" is completed and signed on page 7. It must designate at least one medical provider.

Any questions? Please contact Link Transit Guest Services at 509-662-1155.

*If Legal Guardian or Power of Attorney will be signing on your behalf, please provide the appropriate documentation.

NOTIFICATION

Once completed, send all pages of the completed application to us:

FAX: 509-664-4095 or

Mail: LinkTransit
Attn: Guest Services/LinkPlus
300 South Columbia
Wenatchee, WA 98801

Scan & Email: guestservices@linktransit.com

After receipt and review of your completed application form, Link Transit may contact you to schedule a telephone interview. We will make eligibility determinations *within 21 calendar days* from the completed interview and we will notify you by mail on how LinkPlus can assist you with your travel needs.

BASIC LINK TRANSIT INFORMATION

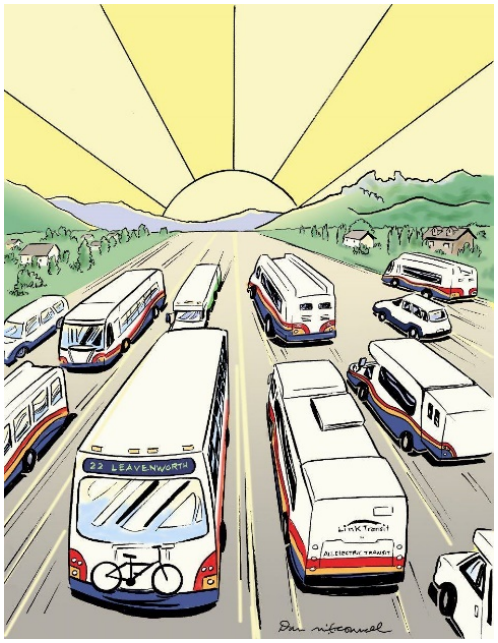
Guest Services phone: (509) 662-1155

Hours of Operation

Monday – Friday: 6 a.m. to 6 p.m.

Saturday: 8 a.m. to 5 p.m.

Sunday: Guest Services is closed.



More information & route schedules:

On line at www.linktransit.com/services

DID YOU KNOW?

Link Transit offers free training to learn how to ride the standard bus! Participation in travel training is not a basis to limit or deny your LinkPlus eligibility. Are you interested? Call for your personal Travel Trainer today at (509) 662-1155!

LINKPLUS ELIGIBILITY APPLICATION

OFFICE USE ONLY:
ID NUMBER:_____ ADA: 1 3 T PCA Y / N Re-Cert to:_____ eCO__ FMP__

LinkPlus assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. For more information, visit www.linktransit.com/more_about_link_transit/

All phone numbers are accessible for people who are deaf or hard of hearing through WA State Relay 711. To request alternative formats of this document, please call 509-662-1155.

Contact Information (Please print)

Last Name: _____ First Name _____ M.I. ___

Nick Name? _____ Date of Birth _____

☐Male ☐Female Do you prefer ☐English ☐Spanish ☐Other? _____

Mailing Address _____Apt./Sp. # _____

City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____

Email Address (optional)_____

If your street address is different from your mailing address; please list it here:

Street Address: _____Apt./Sp. # _____

City _____ State _____ Zip _____

Emergency Contact:

Name: _____ Relationship _____

Home Phone (_____)_____ Cell Phone (_____)_____

If we are unable to contact you, please list an alternate contact:

Alternate contact: (if different from Emergency Contact)

Name: _____ Relationship _____

Home Phone (_____)_____Cell Phone (_____)_____

By providing emergency/alternate numbers, you authorize Link transit or its representatives to contact the individuals listed regarding your paratransit service.

Choose option A *or* B:

☐ **A:** Include a list of your current medical diagnoses from your doctor's office. This option may expedite the application process. (Must be an official document from your medical record or doctor.) ***OR***

☐ **B:** Complete this page. Check any of the medical conditions below that apply.

1. Bone and Joint Conditions

☐ Amputation
☐ Broken Bones: *Date*_____
☐ Arthritis
☐ Osteo-arthritis/Osteoporosis
☐ Rheumatoid Arthritis
☐ Knee replacement: *Date*_____
☐ Hip replacement: *Date*_____

2. Brain/Nerve/Muscle Condition

☐ Dementia Type: _____
☐ Alzheimer's Disease *Stage*___
☐ Multiple Sclerosis
☐ Brain Injury: *Date*_____
☐ Parkinson's Disease *Stage*___
☐ Muscle Dystrophy
☐ Stroke/CVA: *Date*_____
☐ Neuropathy
☐ Fibromyalgia
☐ Paraplegia/Quadriplegia
☐ Cerebral Palsy
☐ Post-polio
☐ Epilepsy/Seizures: *How often in the last 6 months?*_____
☐ Vertigo/Dizziness
☐ Memory Difficulties - Recent memory test: *Date:*_____ *Results:*_____

3. General Medical Conditions

☐ Diabetes-Controlled/Uncontrolled
☐ Kidney Failure
☐ Dialysis:
☐ Organ Transplant: *Date*_____
☐ Cancer: *Date* _____
___ *No. times weekly?*
Treatments? _____
___ *No. times weekly?*

4. Heart and Circulatory Conditions

☐ Congestive Heart Failure
☐ Cardio Vascular Disease
☐ Heart Attack: *Date*__
☐ Take Coumadin
☐ Edema
☐ A Fib
☐ Carry Nitroglycerin
☐ Heart Surgery/Transplant: *Date*_____

5. Lung and Breathing Conditions

☐ Lung Cancer
☐ Cystic Fibrosis
☐ Asthma
☐ Emphysema
☐ COPD
☐ Use Oxygen
☐ 24/7
☐ Night only
☐ Sometimes

6. Hearing/Speech/Vison Conditions

☐ Partial Hearing Loss
☐ Legally Deaf
☐ Impaired Speech
☐ Glaucoma
☐ Partially Sighted *
☐ Macular Degeneration*
☐ Cataracts *
☐ Legally Blind*
☐ Visual Field Deficit*

**Do you know your visual acuity? Right eye:* _____*Left eye:* _____*Combined:*_____
It would be helpful to have this information from your eye doctor if you have a severe visual disability.

7. Developmental Disabilities:

☐ Downs Syndrome ☐ Intellectual Disability ☐ ADHD ☐ Autism Spectrum Disorder

8. Behavior Health: (*please list your mental health provider on the consent form on page 7*)

☐ Bipolar Disorder ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Anxiety Disorder

9. Anything we missed? List Other here:_____

_____

ABOUT YOU

1. Referencing the previous page or your list of medical diagnoses, what do you feel are the *top 3 conditions* that limit your mobility or ability to use public transit?
   a._____ b. _____ c. _____

2. Explain how you believe *each of the above* prevents you from riding the bus? (use Attachment B if needed)
   a._____
   b._____
   c._____

3. Do your limitations change from time to time because of medical treatments, medications, or for other reasons?
   ☐No ☐Yes, please describe (use Attachment B if needed)
   _____
   _____
   _____

4. Is your need for LinkPlus service long term or temporary?
   ☐Long term ☐Temporary - How Long _____?

5. Is your memory affected due to your disability/limiting conditions?
   ☐No ☐Yes If yes: ☐Short term ☐Long term

6. Do you currently ride the standard bus? ☐No ☐Yes ☐Sometimes (If you checked "Sometimes" please explain the circumstances in which you ride)
   _____
   _____
   _____

7. Have you ever ridden the standard bus without someone's assistance?
   ☐No ☐Yes If yes, how long ago_____

YOUR MOBILITY

8. Are you able to independently:
   - Travel to and from a bus stop? Yes☐ No☐
   - Get on and off a ramp-equipped bus? Yes☐ No☐
   - Ask for, understand, and/or follow directions? Yes☐ No☐
   - Plan, understand, and follow through with the actions necessary to take a bus trip? Yes☐ No☐

9. Which of the following mobility aides or equipment do you use when you leave your home? Check all that apply.

☐No aids
☐Motorized wheelchair
☐Support cane
☐Crutches
☐Walker
☐White cane
☐Motorized scooter
☐Manual wheelchair
☐Other (please specify) _____

More than one aid? Please describe the circumstances when you use each one.

Type of mobility aid	Purpose
_____	_____
_____	_____

If you use a wheelchair device or scooter, please list the make & model:
(*If you are unsure, see Attachment C for assistance*.)

_____

10. LinkPlus may not be able to transport mobility aids that are larger than:

• 30+ inches in width • 48+ inches in length • 800lbs+ when occupied

Does your mobility aid exceed any of these measurements?
☐ No ☐Yes, it does. Explain specifics.

_____

_____

If you use a motorized wheelchair or scooter, skip to question 13.

11. When you walk outside your home, how far can you walk by yourself *or with* the use of a mobility aid such as a cane or walker?

Number of blocks _____ ☐Less than 1 block ☐Not at all

12. If you use a manual wheelchair, how far are you able to self-propel?
    Number of blocks _____ ☐Less than 1 block ☐Not at all

13. If you use a motorized wheelchair or scooter, how far are you able to travel without someone to physically assist you?
    Number of blocks _____ ☐Less than 1 block ☐Not at all

14. Some passengers need to have their feet elevated or their chair in a reclined position. Can your chair remain in an upright or sitting position with the feet down for the duration of the bus ride? ☐Yes ☐No, please explain:

    _____

    _____

    _____

15. Does your residence have an approved ramp and/or flat, smooth path to get from your door to the bus? ☐Yes ☐No it doesn't. Please explain:

    _____

    _____

    _____

16. If you qualify for LinkPlus services will you need to use the lift (in opposed to a ramp or steps) to board the bus? ☐No ☐Yes

Link Transit does not provide custodial care. Drivers may only provide assistance to and from the front door of a home or business as long as they can maintain line-of-sight of their vehicle and may only carry bags or packages not exceeding 25lbs in combined weigh. Persons requiring assistance while waiting, riding in a vehicle, or understanding may have a Personal Care Attendant (PCA) ride with them at no additional cost.

17. Will you need to bring a helper (Personal Care Assistant)?
    ☐No ☐Yes ☐Sometimes

    Describe how your personal care attendant helps you?

    _____

    _____

18. If there anything else about your disability/limiting condition that might help us better understand your travel abilities and limitations please use Attachment B.

AGREEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this application, you authorize the release of information to Link Transit or its representatives to evaluate your eligibility for LinkPlus service. Please be advised that we will use your statements to determine your eligibility for LinkPlus service.
Link Transit may share your eligibility determination with other transportation providers, upon request, to facilitate travel in other transit districts.
This form must be signed by the applicant or, if applicable, by the applicant's Legal Guardian. If the applicant is under 18 years of age, a parent or Legal Guardian must sign this form.

If a Legal Guardian will be signing this application the following attachments are required: Copies of current Letters of Guardianship and the Order Appointing Guardian document from the court.

I HEREBY CERTIFY under the penalty of perjury, under the laws of the State of Washington that the information provided on this application is true and correct.

Signature (*required*): _____ Date: _____

Please check one. ☐ Applicant ☐ Legal Guardian ☐ Power of Attorney

Printed name: _____Phone (____)_____

If a **Legal Guardian**, please attached documentation.

If **Power of Attorney** legal documentation is not required at this time. However, if needed copies may be requested.

ALTERNATE ASSISTANT (only if not acting as Guardian or POA)
If you are assisting or acting as the applicant's representative please complete the following, Please note, the **Applicant must still sign in the signature line above**.

Name: _____ Phone: (____)_____

Relationship to applicant: _____

Facility name if applicable: _____

Transit Evaluation **Informed Consent/Professional Verification Release Form**

Applicants Name:_____Date of Birth:_____
please print your legal name

In order for Link Transit to complete the application process, it may be necessary to contact a physician or other professional to confirm the information you have provided. Please identify the professional **best able** to verify your functional ability to use transit services.

The following professional(s) is/are familiar with my disabilities: **please print**

Professional's Name:_____Phone:_____

Address:_____City:_____Zip:_____

Provides treatment for:_____

Professional's Name:_____Phone:_____

Address:_____City:_____Zip:_____

Provides treatment for:_____

Other: A friend, family member or care provider who you would want us to contact who is familiar with your need for Link Plus services.

Name:_____Phone:_____

Address:_____City:_____Zip:_____

Relationship: _____

"I certify that the information I provide in this evaluation is true and correct to the best of my ability and will be kept confidential and reviewed only by those performing the evaluation. I understand that Link Transit may need to contact the professional(s)/individual(s) identified above in order to assist in the determination of eligibility. I hereby authorize the above professionals/individuals to provide Link Transit with any information required to complete this application."

Applicant Signature: _____Date_____
(*Applicant signature required if no legal POA or Guardian.*)

Guardian/POA Signature: _____Date:_____
(Please attach a copy of Guardianship or POA documents)

Guardian/POA Name _____
Please Print

Relationship (if applicable) _____

Attachment A:

Name: _____ Date: _____ Pg. 8

WHAT ARE YOUR COMMON TRIPS?

So that we may ensure the accessibility of locations to which you may frequently travel, please list the trips (physical address) you are most likely to take. An example would include from home to: friends or family members home, work, doctor's office, shopping, etc.

Please print

Destination (Name of Business or Individual):_____

Address: _____ City: _____

Destination (Name of Business or Individual):_____

Address: _____ City: _____

Destination (Name of Business or Individual): _____

Address: _____ City: _____

Destination (Name of Business or Individual):_____

Address: _____ City: _____

Destination (Name of Business or Individual):_____

Address: _____ City: _____

Destination (Name of Business or Individual): _____

Address: _____ City: _____

Attachment B:

Name: _____ Date: _____

LINKPLUS ELIGIBILITY APPLICATION

EXTRA PAGE FOR ADDITIONAL APPLICANT INFORMATION

Question No.

Attachment C:

Name: _____ Date: _____

LINKPLUS ELIGIBILITY APPLICATION

MOBILITY AIDE CHEAT SHEET

If you need help determining what type of manual wheelchair, power wheelchair or power scooter you use **circle the picture that most looks like your device. Then please complete the answers on page 3.**

☐ *Manual Wheelchair that looks most like this: (Circle one)



☐ *Power Wheelchair that looks most like this: (Circle One)



☐ *Power Scooter that looks most like this: (Circle one)