LINC Transportation Program Application

Legal Name: _____ Phone: (_____) _____

Address: _____ Apt. # _____ City: _____ Zip: _____

Date of Birth: _____Email: _____

Gender: ☐ Male ☐ Female
Pronouns: _____

A copy of a State Issue ID is required to process this application

Veteran: ☐Yes ☐No

Ethnicity:
☐ Hispanic/Latino
☐ NOT Hispanic/Latino

Race: ☐ American Indian/Alaska native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White
☐ I'd rather not say

How did you hear about LINC? _____

Do you need accommodations for communication? If so, what? (Braille, Large Print,

Interpreter, Captioning): _____

The following section required for those under 60 years old

The disability is: ☐Permanent ☐Temporary
Disability Projected End Date: _____
Provider Name and Organization: _____
Address: _____
Phone: _____ Email: _____
As a licensed health care professional, I certify that this applicant has a disability that prevents or seriously limits their ability to drive.

Signature: _____

Title VI of the Civil Rights Act

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. LINC's transportation program receives Federal funds and is required to comply with Title VI. For more information, or to file a complaint, call (208) 336-3335 or go to www.lincidaho.org/transportation for the complaint process and form.

Card #_____ (For use by LINC staff only)

LINC Consumer Eligibility Form

I, _____, state that I have the following disability(ies):

_____ _____

Primary Disability Secondary Disability

My disability(ies) substantially limits me from functioning independently in the following area(s):

____ self-care ____ employment

____ mobility ____ housing

____ education ____ other (specify): _____

The services I am requesting will help me: (check all that apply)

___ improve my ability to function in my family or community

___ maintain my ability to function in my family or community

___ obtain, maintain or advance in employment

I understand that it is my choice to have services provided to me under an Independent Living Plan (ILP), a formal plan which states my goals and services I will receive) or I can choose to waive a plan. I choose:

___ Independent Living Plan ___ Waive Independent Living Plan

_____ _____

Consumers Signature Date

By signing below, I determine as a representative of LINC that the applicant is eligible for services and has met the basic requirements specified in Section 364.4

_____ _____

IL Specialist Signature Date

Individual Rights and Responsibilities

_____ I understand that a written record will be maintained regarding activities, goals, services, and loans with LINC. All of the information shared between myself and LINC is protected in alignment with HIPAA laws. I can ask for details about these laws at any time.

_____ This plan is about me, **my** dreams, and **my** goals to achieve and/or maintain independence. I can change my plan at any time. I understand that reaching them will require active participation and cooperation. This includes the keeping of appointments, scheduled activities, and any needed tasks that are part of my Independent Living Plan (ILP).

_____ I understand that a LINC staff member may close my file at any time including when I have not actively participated, for any illegal activities, or any threatened or real violence.

_____ I will give my feedback on my services and training if given a satisfaction survey.

_____I know that I can request communications in an alternative format (braille, large print, captioning, interpreting, etc.)

_____ I understand that in the event I am unsatisfied with the services I have received or wish to appeal any decision made by LINC, I may contact the Director of Independent Living Innovation or Executive Director at (208) 336-3335.

_____ I have received a copy of Client Assistance Program (CAP) information for assistance in resolving any consumer issues or complaints.

_____ Date:_____
Signature of Consumer

_____ Date:_____
Signature of LINC Staff